J & J Artificial Limb & Brace
15644 Pomerado Rd. Suite 103, Poway, Ca. 92064
Tel. 858-613-0958 Fax. 858-613-0959
www.jandj.org

Patient's Information											
First Name		**Middle Initial**		**Last Name**							
Date of Birth		**Age**		**Sex**		**Marital Status**		**SS#**			
Home Address				**City**		**State**		**Zip**			
Mailing Address				**City**		**State**		**Zip**			
Home Phone #	( )	**Cell #**	( )			**Work #**	( )				
Email Address				**Best Time & Place to Reach You**							
Employer's Name				**Occupation**							
Employer's Address				**City**		**State**		**Zip**			
Primary Care Physician				**Phone#**	( )						
Physician's Address				**City**		**State**		**Zip**			
How did you hear about us?											

Parent/Guardian's Information (PLEASE COMPLATE THIS SECTION IF PATIENT IS A MINOR)							
First Name		**Middle Initial**		**Last Name**			
SS#		**Date of Birth**		**Relationship to Patient**			
Employer's Name			**Occupation**				
Employer's Address			**City**		**State**		**Zip**
Employer's Phone #	( )						

Spouse Information							
First Name		**Middle Initial**		**Last Name**			
SS#		**Date of Birth**		**Relationship to Patient**			
Employer's Name			**Occupation**				
Employer's Address			**City**		**State**		**Zip**
Employer's Phone #	( )						

Emergency Contact							
First Name		**Middle Initial**		**Last Name**			
Home Phone #	( )	**Cell #**	( )		**Work #**	( )	
Relationship to Patient							

Primary Insurance Information							
Insurance Name					**Phone #**	( )	
If HMO, Who is the Medical Group					**Phone #**	( )	
Claims Address		**City**		**State**		**Zip**	
Subscriber's Name				**Relationship to Patient**			
Member/Subscriber's ID#				**Group #**			
Subscriber's Date of Birth				**SS#**			

Secondary Insurance Information							
Insurance Name					**Phone #**	( )	
If HMO, Who is the Medical Group					**Phone #**	( )	
Claims Address		**City**		**State**		**Zip**	
Subscriber's Name				**Relationship to Patient**			
Member/Subscriber's ID#				**Group #**			
Subscriber's Date of Birth				**SS#**			

AUTHORIZATION AND ASSIGNMENT AND RELEASE

I request that payment of authorized CMS benefits be made either to me or on my behalf to J& J Artificial Limb and Brace for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In CMS assigned case, the physician or supplier agrees to accept the charge determination of the CMS carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the CMS Carrier.

I, the undersigned certify that I (or my dependent) have insurance coverings with the above company(s) and assign directly to J & J Artificial Limb and Brace all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize J & J Artificial Limb and Brace to release all information necessary to secure the payment of benefits. In the event my insurance company forwards payment directly to me, instead of J & J Artificial Limb and Brace, I will immediately deliver such payment to J & J Artificial Limb and Brace. I authorize the use of this signature on all insurance submissions.

_____ _____

RESPONSIBLE PARTY SIGNATURE Date

Revised 3/30/07