



TriTek Orthopaedics, LLC

Tel (TOLL-FREE) 866-584-5502

Fax (TOLL-FREE) 866-576-9361

270 Redwood Shores Pkwy, #509
Redwood Shores, CA 94065

PATIENT INFORMATION FORM

PLEASE HAVE PATIENT SIGN AND DATE THIS FORM FOR
RECEIPT OF THEIR TRITEK ORTHOPAEDICS, LLC UNIT

PLEASE FAX TO 866-576-9361

PATIENT

NAME			SOCIAL SECURITY NUMBER		
ADDRESS			BIRTH DATE		YEAR
		MONTH	DAY		
CITY	STATE	ZIP	HOME PHONE		WORK PHONE

INSURANCE

INSURER	
BILLING ADDRESS	
PATIENT'S RELATIONSHIP TO INSURED	
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	
POLICY NUMBER	GROUP NUMBER

SELF-PAY PATIENTS

CREDIT CARD INFORMATION	
<input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMEX <input type="checkbox"/> DINER'S CLUB	
ACCOUNT NUMBER EXPIRATION DATE	
OTHER PAYMENT	

WORK COMP/AUTO

WORK COMP	AUTO CARRIER	CLAIM NUMBER
BILLING ADDRESS		
CITY	STATE	ZIP
ADJUSTER'S NAME	PHONE	
EMPLOYER	DATE OF INJURY	

ATTORNEY/LIEN

ATTORNEY NAME		
LAW FIRM		
PHONE		
ADDRESS		
CITY	STATE	ZIP

WORKER'S COMPENSATION: RIGHT TO CHOOSE

The equipment I received is the equipment ordered by my authorized physician. I choose to use this particular equipment supplied by TriTek Orthopaedics, LLC. I chose TriTek Orthopaedics, LLC as my provider and understand that I have this right if applicable under the worker's compensation law in the state of my residence. My insurance carrier may NOT CHANGE the equipment or provider without my prior knowledge and written approval. I choose TriTek Orthopaedics, LLC as the provider of any future supplies and accessories.

PHYSICIAN

PRESCRIBING PHYSICIAN
PHONE
DIAGNOSIS
ICD-9-CM

CLINICIAN

CLINIC
PHONE
PHYSICAL THERAPIST
DO NOT ISSUE TO PACEMAKER PATIENTS

EQUIPMENT

DESCRIPTION	MODEL #	SERIAL #
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I have been instructed in the proper application, use and care of the above described unit. I may rent or purchase the system. I understand that I am responsible for the return of the TriTek Orthopaedics, LLC equipment and if for any reason, I do not return the unit directly to TriTek Orthopaedics, LLC, I agree to pay the rental or purchase price. I authorize the release of any medical information necessary to process my claim and I agree to pay for all charges not covered by this authorization or not otherwise paid by my insurance company. I permit a copy of this authorization to be valid as the original. I, the undersigned, select TriTek Orthopaedics, LLC as my DME provider of choice and represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to TriTek Orthopaedics, LLC surgical and medical benefits, if any, otherwise payable to me for the services described. I understand that I am financially responsible for all charges, whether or not paid for by said insurance. I hereby authorize said assignee to release and obtain all information necessary to secure payment of said benefits and authorize TriTek Orthopaedics, LLC or its representatives to inspect the claim file relating to the claim identified above. I have read, understand, and agree to the contract above.

PATIENT'S SIGNATURE _____

DATE _____

INSURED SIGNATURE (if different from patient) _____

DATE: _____