Walking and Wheeling, LLC
REGISTRATION FORM

Today's Date:	PCP:	Health Facility:	City:	Phone:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Status:	Marital status:	Ethnicity:
Is this your legal name? ___ Yes ___ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ___ M ___ F

Address:	Family Email Address:

Mother's full name:	Address:	Phone no.:	DOB:
Father's full name:	Address:	Phone no.:	DOB:
Legal Guardians:	Address:	Phone no.:	

Name of Physical Therapist:	Phone no.:	Email:
Name of Occupational Therapist:	Phone no.:	Email:
Name of Social Worker:	Phone no.:	Email:
Name of County Worker:	Phone no.:	Email:

INSURANCE INFORMATION

Please email photos of the front and back side of your insurance card to info@walkngandwheeling.com

Person responsible for bills:	Birth date:	Address (if different):	Home phone no.:
Is this person a new patient here?	___ Yes ___ No	Is this patient covered by insurance? ___ Yes ___ No	Other Payment Source: ___ Self Pay ___ CLTS ___ CCOP

Please indicate primary insurance:

Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of tertiary insurance (if applicable):	Subscriber's name:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Walking and Wheeling, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________

Walking and Wheeling, LLC
W4652 Glenn Street
Appleton, WI 54913
920-968-7528

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Patient's Primary Medical Diagnosis:

Additional Diagnoses:

Onset of Primary:

Surgical History (include dates):

	Please select medical equipment that the patient owns or is currently using:	Owns and uses at home	Uses at school	Uses with Therapist	Does the patient currently wear orthotics: ___ Yes ___ No (if yes, select all that apply)	
	Wheelchair					AFOs foot orthotics
	Adaptive Stroller					SMOs foot orthotics
	Stander					WHOs – wrist hand orthotics
	Gait Trainer/Walker					SPIO, Benik, Theratogs
	Alternate Positioning Chair					Helmet
	Bath Chair					Hensinger Collar
	Toileting Chair					
	Hospital Bed					
	Adaptive Trike/Bike					
	Other					

Patient's Current Height:

Patient's Current Weight:

Comments/Additional Information:

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