

## Walking and Wheeling, LLC REGISTRATION FORM

Today's Date:	PCP:	Health Facility:	City:	Phone:	
<b>PATIENT INFORMATION</b>					
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:	
<b>INSURANCE INFORMATION</b>					
Please email photos of the front and back side of your insurance card to <a href="mailto:info@walkngandwheeling.com">info@walkngandwheeling.com</a>					
Person responsible for bills:	Birth date:	Address (if different):		Home phone no.:	
Is this person a new patient here? ___ Yes ___ No	___ 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:					
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	
<p>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.</p>					
_____ Patient/Guardian signature			_____ Date		



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

## Walking and Wheeling, LLC REGISTRATION FORM

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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\_\_\_\_\_  
Patient/Guardian signature \_\_\_\_\_  
Date



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