TILLGES
ORTHOTICS & PROSTHETICS

PATIENT REGISTRATION

Patient Information (CONFIDENTIAL) PT Tillges ID # (office use) _____

First & Last Name _____ Birthdate _____

Address _____ City_____ State _____ Zip _____

SS# _____ Driver's License # _____

Cell Phone _____ Home Phone _____

E-mail _____

Emergency Contact _____ Phone _____

Primary Care Physician _____ Clinic Name/Phone _____

How did you hear about Tillges?

☐ Doctor ☐ PT/OT ☐ NP/PA ☐ Family/Friend ☐ Social Media ☐ Print Ad ☐ Other _____

Responsible Party – *Fill out ONLY for minor children or patients with a POA or Guardian*

Person responsible for patient's account _____

Relationship to patient _____ SS# _____

Driver's License # _____ Birthdate _____

Address _____ City _____

State _____ Zip _____

Cell Phone _____ Home Phone _____

Email _____

PLEASE PROVIDE ALL INSURANCE CARDS TO FRONT DESK STAFF TO ENSURE CORRECT INSURANCE BILLING.