7791 Cooper Road Ste. H
Cincinnati, Ohio 45242
Phone: 513-793-7335
Fax: 513-985-3865
800-918-9188

BIO WORKS

PATIENT INFORMATION SHEET

PATIENT NAME	MARITAL STATUS	SEX ☐M ☐F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

PATIENT ADDRESS	CELLPHONE NO.	HOME PHONE NO.

CITY	STATE	ZIP	ALT PH NO. & NAME	EMAIL

PATIENT'S EMPLOYER	WORK NO.	ADDRESS

SUBSCRIBER'S NAME	SEX ☐M ☐F	INSURED EMPLOYER	DATE OF BIRTH	RELATION TO PATIENT ☐SELF ☐SPOUSE ☐PARENT ☐OTHER	SOCIAL SECURITY NO.

PRIMARY INSURANCE COMPANY	MEMBER ID#	GROUP NAME	GROUP NO.

ADDRESS	PHONE NO.

SUBSCRIBER'S NAME	SEX ☐M ☐F	INSURED EMPLOYER	DATE OF BIRTH	RELATION TO PATIENT ☐SELF ☐SPOUSE ☐PARENT ☐OTHER	SOCIAL SECURITY NO.

SECONDARY INSURANCE COMPANY	MEMBER ID#	GROUP NAME	GROUP NO.

ADDRESS	PHONE NO.

IS THIS WORKMAN'S COMP ☐YES ☐NO DOI:___/___/___	IS THIS AN AUTO ACCIDENT ☐YES ☐NO DOI:___/___/___	ATTORNEY NAME & PHONE NO.

B.W.C. CLAIM NO.	EMPLOYER AT TIME OF ACCIDENT	MCO NAME

PHYSICIAN'S NAME	ADDRESS	PHONE NO.

PRODUCT SERIAL #	MANUFACTURER	DIAGNOSIS

DATE PRODUCT ISSUED TO FACILITY	HOSPITAL OR FACILITY ISSUED FROM

PRODUCT DESCRIPTION	PRICE	TAX	TOTAL

GUARANTEE OF PAYMENT AND MEDICAL RELEASE

The above information is correct and complete to the best of my knowledge. I understand that I am responsible for any charges not covered by my insurance, and that these charges should be paid within thirty days of insurance response. Payment not made when due may incur interest at a rate of 1.5% per month. If any amount must be collected through any agency, fees in the amount of 25% shall accrue with the minimum being $25.00. I acknowledge that this equipment was prescribed by a physician and release Bioworks, Inc. of any claims resulting from use.

I hereby authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Bioworks, Inc. for services rendered.

X_____ _____

Guarantors Authorization Signature Date

In order for Bioworks to file with your insurance company or Workers Compensation, the above information must be completed in full and a prescription must be attached.