

PATIENT INFORMATION FORM

Please Print ALL Information Legibly

Section 1 - Patient Information

Where did you hear about us? _____
Patient Name: _____ SSN: _____ Date Of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Telephone # : _____ Work Tel. #: _____ Mobile # : _____
Sex: (circle one) Male / Female Marital Status: (circle one) Single / Married / Other HT: _____ WT: _____
Patient's Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Spouse's Name: _____ Phone # : _____ SSN: _____

Section 2 - Parent / Guardian / Responsible Party (If other than Patient)

Relationship to Patient: (circle One) Spouse / Parent / Guardian / Other (Explain) _____
Name (Last, First, MI): _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Tel # : _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

Section 3 - Emergency Contact

Name (Last, First, MI): _____ Relationship: _____
Home Tel # : _____ Work Tel : _____

Section 4 - Medical Information

Diagnosis: _____ Date of Injury: _____
How / Where did the injury occur: _____
Primary Care Physician: _____ Tel # : _____
Referring Physician/ Referral Source: _____ Tel # : _____
Are you Diabetic ? (circle one) YES / NO Physician Managing Diabetes: _____ Tel # : _____
What medications are you currently taking?: _____
If Amputation, Amputation Date: _____ Level of Amputation: _____ Amputation Side: R L BIL

(Continue on next page)

Section 5 - Insurance Information

Is this Worker's Comp Claim? Y / N (If yes, please complete WORKER'S COMP form)

Is this due to an Auto/Home accident: Y / N Date of Injury: _____ State that accident occurred in: _____

Auto/Home Insurance Carrier: _____ Policy # : _____

Contact Person: _____ Tel # : _____

Primary Insurance: _____

Policyholder: _____

Policyholder Date of Birth: _____

Policyholder SSN: _____

Group # : _____ ID # : _____

Patient's Relationship to Policyholder: _____

Secondary Insurance: _____

Policyholder: _____

Policyholder Date of Birth: _____

Policyholder SSN: _____

Group # : _____ ID # : _____

Patient's Relationship to Policyholder: _____

Has the patient received a like or similar device within the last 3 (three) years from any other provider? YES / NO

If yes, when and name of other provider : _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the prosthetist/orthotist as soon as possible. If deemed advisable. I grant permission for my physician to be contacted for details and advise. I further authorize the taking of photographs and/or other diagnosis measures for a thorough evaluation. I hereby authorize Orthotic & Prosthetic Tech., Inc. to release or obtain any information required in the course of my examination and/or treatment.

Signature: _____ Date: _____