PATIENT REGISTRATION AND MEDICAL HISTORY

PATIENT INFORMATION:

Name____ Home Phone____________________________

Address_______________________________________ City__________________________ State_______Zip__________

Male___ Female____ Age________ Date of birth_________________ Soc. Sec. ___________________________________

Employed by____ Business Phone_____________________

Name of contact person (not living with you)_____________________________________ Phone____________________

PRIMARY INSURANCE:

Insurance Company_______________________________________Subscriber_____________________________________

Subscribers ID #___________________________ Group #___________________ Relationship to Patient______________

Subscriber Employed by____ Business Phone________________________

ADDITIONAL INSURANCE:

Insurance Company_____________________________________ Subscriber______________________________________

Subscribers ID #___________________________ Group #___________________ Relationship to Patient______________

Subscriber Employed by____ Business Phone________________________

WORK RELATED CLAIM: Claim #__________________________________ Date of Injury_______________________

PATIENT MEDICAL HISTORY:

Have you ever had any of the following? (check all that apply)

_____Heart Problems _____Back Problems _____Diabetes _____Arthritis

_____Circulation Problems _____Respiratory Disease _____Stroke

_____Amputation of limb (please circle what level of amputation):
Above Knee Below Knee Foot Only Toe(s) Only Above Elbow Below Elbow

Date of Amputation________________________

Prescribing Physician_________________________________ Date last seen by the prescribing physician_______________

IMPORTANT:

Your physician is prescribing an orthopedic or prosthetic device. Please indicate if you have received a similar device from another facility within the last 24 months: _____Yes ______No Approximate date received: ________________