PATIENT INFORMATION

Name: _____ ❒ Male ❒ Female
Last First M.I.

Address: _____

City: _____ State: _____Zip:_____

Phone Number Home: ( ) _____-_____ Work/Cell: ( ) _____-_____

Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Email Address :_____

Responsible Party if other than patient: _____ Phone#: ( ) _____-_____

MEDICAL INFORMATION

Primary Physician:_____ NPI#_____

Phone #: ( ) _____-_____ Fax #: ( ) _____-_____

Diagnosis: _____ ❒ Left ❒ Right ❒ Bilateral Diabetes: ❒Yes ❒ No

Date of Injury or Date of Amputation: _____ Height: _____ Weight: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: ( ) _____-_____

Policy Holder Name: _____ Policy Holder D.O.B. _____/_____/_____

Insurance Address: _____City: _____ State: _____ Zip: _____

ID #: _____ Group #: _____

Secondary Insurance: _____ Phone: ( ) _____-_____

Policy Holder Name: _____ Policy Holder D.O.B. _____/_____/_____

Insurance Address: _____ City: _____State: _____ Zip: _____

ID #: _____ Group #: _____

Workers Comp Only:

Claim #: _____ Adjuster: _____

Employer at time of Injury: _____Phone #: ( ) _____-_____

I (or my dependent) am aware that I have a condition requiring orthotic/prosthetic management and treatment by the professional staff of Prosthetic Solutions. I am aware and acknowledge that no guarantees have been made to me regarding the results of any treatment or examinations by representatives of Prosthetic Solutions. I authorize the release of any information acquired in the course of treatment by Prosthetic Solutions. I understand that Prosthetic Solutions will assist me in billing my insurance company for services provided. This facility is not liable for any guarantee of insurance benefits released to us by your insurance company. I also understand that I am responsible for the balance not covered under my policy for these services. I certify that I have read, understand, and agree to the statements and information contained herein

Signature: _____ **Date:** _____