PRECISION
PROSTHETICS &
ORTHOTICS

Patient Registration Form

PATIENT INFORMATION:

Patient's Legal Name (Last, First, Middle) _____ Nickname: _____

Soc. Security No: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Marital Status. ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Care Physician _____ Home Ph: _____ Cell: _____ Email: _____

Patient's Street Address: _____ City: _____ State: ____ Zip: _____

PO Box: _____ PO Box Zip Code: _____

Employer: _____ Emp. Address (Street, PO Box) _____

City: _____ State: ___ Zip: _____ Employer Phone No _____ Extension _____

Reason for Visit _____ Who referred you to us? _____

Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No

Do we have your permission to record, videotape and/or photograph your image and/or voice? ☐ Yes ☐ No

PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL ☐ Check here if same as above

Name (Last, First, Middle) _____ Home Ph: _____ Cell: _____ Email: _____

Street Address (Required): _____ City: _____ State: ____ Zip:

PO Box: _____ PO Box Zip Code. _____ Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Self ☐ Other _____

Employer: _____ Emp. Address (Street, PO Box) _____

City: _____ State: ___ Zip: _____ Employer Phone No.: _____ Extension: _____

How are you paying today? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Workman's Comp. ☐ Company Account

EMERGENCY CONTACT

Name (Last, First, Middle) _____ Home Ph: _____ Cell. _____ Email: _____

Street Address (Required): _____ City: _____ State: ____ Zip: _____

PO Box (if applicable) _____ Employer Phone No.: _____ Extension: _____

Relationship to Patient: ☐ Parent ☐ Child ☐ Spouse ☐ Other _____

INSURANCE INFORMATION

Name of Primary Insurance:

Member/Policyholder (if different from patient): (Last, First, MI)

_____

Member/Policyholder ID#: _____ Date of Birth _____

Insurance Co. Phone No. _____ Group No. _____

Insurance Co. Address (Street Addr. / PO Box)

_____

City: _____ State: ____ Zip: _____

Name of Primary Insurance:

Member/Policyholder (if different from patient): (Last, First, MI)

_____

Member/Policyholder ID#: _____ Date of Birth _____

Insurance Co. Phone No. _____ Group No. _____

Insurance Co. Address (Street Addr. / PO Box)

_____

City: _____ State: ____ Zip: _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to this physician practice for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

***Insurance coverage and authorization is NOT a guarantee of payment. Any returned check will be assessed a $35.00 fee.**

Signed: _____ Date: (Month/Date/Year) _____ / _____ / _____

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Medical History Form

Height _____ ☐ Ft./In. ☐ Cms. Weight _____ ☐ Lbs. ☐ Kgs. ☐ With Device?

Shoe Size: _____ Are you diabetic? ☐ No ☐ Yes is yes: Type I ☐ II ☐ Insulin Dependent ☐

Do you use tobacco products?
☐ I have never used tobacco
☐ I currently use tobacco. If so, what type _____
☐ I used tobacco, but quit _____ years / months (circle one) ago
☐ I prefer not to answer

If your condition is the result of an accident or injury? ☐ No ☐ Yes **If yes, please complete below:**

Date of accident/injury ___/___/_____ Where it happened _____
M M D D Y Y Y Y

Description of accident/injury: _____

Have you received any orthotics or prosthetic device(s) within the past five years? ☐ Yes ☐ No If yes, please list item(s) and date: _____

Do you have an amputation? Y / N If yes, [ ] Above Knee [ ] Below Knee [ ] Through Knee [ ] Through Ankle [ ] Partial Foot [ ] Above Elbow [ ] Below Elbow [ ] Other

_____

When did your amputation occur? _____ Month _____Year
(If unsure, please make your best guess)

In the past 6 months, have you lost your balance, slipped or tripped resulting in a fall? ☐ No ☐ Yes If yes, how many falls? ☐ 1 ☐ 2 ☐ 3+ times

Do you have any allergies? ☐ No ☐ Yes If yes, please list below:
Allergies: _____

Do you currently have, or have you previously had, any of the following medical conditions? Please check all that apply:

☐ Alzheimer's or Dementia
☐ Anxiety
☐ Asthma
☐ Attention Problems, (ADHD)
☐ Brain Injury/ TBI
☐ Cancer
☐ Depression
☐ Diabetes Type I
☐ Diabetes Type II
☐ Hearing Loss
☐ Heat Problems
☐ Hepatitis A B C (circle type)
☐ High Blood Pressure
☐ HIV
☐ Infections
☐ Intestinal Problems
☐ Kidney Disease
☐ Liver Disease
☐ Migraines
☐ MRSA
☐ Neurological Problems
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pulmonary Disease (TB)
☐ Rheumatoid Arthritis
☐ Seizure Disorders
☐ Skin Problems
☐ Stomach Problems
☐ Stroke/TIA/CVA
☐ Vascular Disease
☐ Vision Problems

Details or others not listed: _____