BIO-TECH PROSTHETICS & ORTHOTICS PATIENT DEMOGRAPHICS

Patient Information Social Security #:_____

Patient Name: _____ Date of Birth:_____
Last First M.I.

Age: _____ Gender: _____ Height: _____ ft (in.) Weight: _____ lbs. Shoe size:_____

Address: _____
Street City State Zip

Email: _____

Home#: _____ Cell#: _____ Work#: _____

Emergency Contact Person:_____ Phone#:_____

Visit Resulting from Injury

Is this visit today from the result of an injury? YES _____ NO _____ (Injury Date: _____)

Was this injury work related? YES ____ NO ____ Name of Employer: _____

Worker's Comp Insurance Carrier:_____ Claim#:_____

Adjustor's Name:_____ Phone #:_____

Healthcare Information

Referring Doctor:_____ Phone #:_____

Are you having surgery? YES ____ NO ____ Surgery Date: _____ Hospital: _____

Primary Care Office:_____

Primary Care Physician: _____ Phone#: _____

Are you diabetic? YES _____ NO _____ Skin Allergies? NO _____ YES _____

Have you received prosthetic or orthotic care within the past 5 years? YES _____ NO _____

Authorization

I hereby authorize the release of information regarding my condition/treatment, as necessary, to process these and/or related claims. I understand that I am responsible for all fees not covered by Insurance, Medicare, Medical Assistance or other Governmental Agencies or Worker's Compensation.

Signature: _____ Date: _____

PLEASE SUBMIT INSURANCE CARDS