For official use only. Orthotic Device: _____ Account # _____
Notice of Privacy Practices signed by the patient/guardian listed below on this date: _____

Orthotic Patient Information Sheet

Patient Information

Patient's Name: _____ Date: _____

Mailing Address: _____ Physical Address: _____
_____ _____

Phone Number(s) Home: _____ Work: _____ Cell: _____

Social Security Number: _____ Date of Birth: _____

E-Mail Address: _____ Emergency Contact: _____

Marital Status: (Please Circle One) Married Single Widowed Other

Guardian's Name: _____ Relation to Patient: _____

Primary Care Physician's Name, Address, and Phone Number: _____
_____
_____

You were referred by: _____

Insurance Information

Policy Holder: _____

Primary Insurer: _____
Identification Number: _____ Group Number: _____

Secondary Insurer: _____
Identification Number: _____ Group Number: _____

Tertiary Insurer: _____
Identification Number: _____ Group Number: _____

My signature below indicates the information provided on this information sheet and the medical history form (see reverse) is true and correct to the best of my knowledge and ability. I authorize Bio-Medic Appliances, Inc. and any beholder of my medical information pertinent to these services be released to the appropriate authorities as necessary to process insurance claims for services provided. By signing below I authorize insurance payments of medical benefits be made to Bio-Medic Appliances, Inc. Also by signing below, I understand that I will be responsible for any balance on my account not paid for by my insurance, including responsibility for an office evaluation charge if I decide not to receive an appliance from Bio-Medic Appliances, Inc. after evaluation.

_____

Beneficiary Signature or Authorized Representative (note relationship to beneficiary)

Medical History

Please be sure to fill in all areas of this medical history form. Thank you.

Height: _____ Weight: _____

General Health (circle one): Poor Fair Good Excellent

Activity Level (circle one): Low Medium Active Highly Active

Is your condition the results of an accident? YES NO

If yes (circle the appropriate cause)

Work Related Automobile Accident Other

Have you had, or do you have, any of the following (check all that apply):

Heart Problems	____	Hepatitis A or B	____	Vision Problems	____
Hypertension	____	HIV Positive	____	Parkinson Disease	____
Vascular Disease	____	Rheumatoid Arthritis	____	Alzheimer Disease	____
CVA (Stroke)	____	Osteoarthritis	____	Psychiatric Problems	____
Diabetes	____	Obesity	____	Alcoholism	____
Kidney Disease	____	Pulmonary Disease (TB)	__	MRSA	____

Other (please list) _____

Medications: (Please list those you are presently taking, with correct dosage):

_____

_____

_____

_____

Date of last surgery: _____ Surgery was for: _____

Name of surgeon: _____

Cause of surgery: _____

Results: Satisfactory: _____

Unsatisfactory (please explain) _____

_____