For official use only: K Level 1 2 3 4 (please circle) Account #_____
Notice of Privacy Practices signed by the patient/guardian listed below on this date: _____

Prosthetic Patient Information Sheet

Patient Information

Name: _____ Date: _____

Mailing Address: _____ Physical Address: _____
_____ _____

E-Mail Address: _____ Emergency Contact: _____

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

Social Security Number: _____ Date of Birth: _____

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: _____

Type of Amputation: Above Knee: Left Right Above Elbow: Left Right Partial Foot:
(Circle all that apply) Below Knee: Left Right Below Elbow: Left Right Left Right

Stump Sock Size: _____ Shoe Size: _____

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.

_____
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 first amputation: _____ Level of amputation: _____

Cause of amputation: (if congenital, describe) _____
_____

Prosthetic Result (check one) Satisfactory _____ Unsatisfactory _____

Name of surgeon: _____

Condition of other extremities (please check what applies): Normal _____
Vascular Disease _____ Paralysis _____ Other (explain)_____

Did you receive pre-prosthetic training? YES NO
Was post prosthetic training prescribed? YES NO

Date of second amputation: _____ Level of amputation: _____

Cause of amputation: _____

Reasons for replacement of prosthesis (check all that apply): Age _____
Worn Out _____ Outgrown _____ Weight gain _____ Weight Loss _____
Present prosthesis unsatisfactory (please describe): _____
_____