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 Name: _____Date: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Cell Home Work

Secondary Phone number: _____ Cell Home Work

Date of Birth: _____ E-Mail Address: _____

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

Spouse: _____ Phone Number: _____

Emergency Contact (name, relation and number): _____

Primary Care Physician's Name: _____

You were referred by: _____

PT's Name: _____	Phone #: _____	Home or Office
PT's Name: _____	Phone #: _____	Home or Office
OT's Name: _____	Phone #: _____	Home or Office
OT's Name: _____	Phone #: _____	Home or Office

Insurance Information (List Name AND provide insurance card(s) to be copied.)

Primary Insurance: _____ ID# _____
Policy Holder: _____ Group Number: _____

Secondary Insurance: _____ ID# _____
Policy Holder: _____ Group Number: _____

Tertiary Insurance: _____ ID# _____
Policy Holder: _____ 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.

Patient Signature or Authorized Representative (note relationship to patient)

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

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) _____

Current Medications (include name and dosage):

_____
_____
_____
_____

What type of device have you been referred for? _____

Do you already have this type of device? _____

When did you receive it? _____

Who provided it? _____

Who paid for it? _____

Why does it need to be replaced? _____

_____