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

Pediatric Patient Information Sheet

Patient Name: _____ Date: _____
First MI Last

Nickname: _____ DOB: _____ Gender: M F

Mailing Address: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN 1: Name: _____ Relationship to child: _____

Address (if different): _____

Primary Phone Number: _____ Cell Home Work

Secondary Phone number: _____ Cell Home Work

E-Mail Address: _____

PARENT/GUARDIAN 2: Name: _____ Relationship to child: _____

Address (if different): _____

Primary Phone: _____ Cell Home Work

Secondary Phone: _____ Cell Home Work

E-Mail Address: _____

Emergency Contact (name, relation and number): _____

Insurance Information (List name and provide insurance card(s) to be copied.)

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

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

Address Bills to: _____

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.

_____
SIGNATURE of Parent or Guardian DATE

Medical History

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

Primary Physician: _____

Referring practitioner: _____

PT's Name: _____ Phone #: _____ **PT's Name:** _____ Phone #: _____ **OT's Name**: _____ Phone #: _____ **OT's Name**: _____ Phone #: _____	Home School Clinic Home School Clinic Home School Clinic Home School Clinic

Height: _____ Weight: _____

Does patient have any allergies? YES NO If yes, to what? _____

General Health (circle one): Poor Fair Good Excellent

Please list all diagnoses patient has experienced: _____

_____

If patient was injured, how did it occur? _____

Current Medications: _____

What type of device has patient been referred for? _____

What types of brace/splint/orthosis has patient worn in the past? _____

_____

Why is bracing being replaced? _____

Are there other people involved in patient's care authorized to receive information:
(Such as grandparents, stepparents or PCAs)

_____ _____

_____ _____

_____ _____