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

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: _____

Emergency Contact (name, relation, number): _____

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

Spouse: _____ Phone Number: _____

Primary Care Physician's Name: _____

You were referred by: _____

Physical Therapist's Name and Phone Number: _____
I see them at: ____ Home ____ Office

Occupational Therapist's Name and Phone Number: _____
I see them at: ____ Home ____ Office

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

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

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

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

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

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) _____

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

_____

_____

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

Stump Sock Size: _____ Shoe size: _____

Date of first amputation: _____ Level of amputation: _____

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

Name of surgeon: _____

Date of second amputation: _____ Level of amputation: _____

Cause of amputation: _____

Name of surgeon: _____

Do you already have a prosthesis? YES NO

Did you receive pre-prosthetic training? YES NO

Was post prosthetic training prescribed? YES NO

Reasons for replacement of prosthesis (check all that apply): Age _____

Worn Out _____ Outgrown _____ Weight gain _____ Weight Loss _____

If present prosthesis is unsatisfactory (please describe): _____

_____