PATIENT INTAKE

NAME		DATE OF BIRTH / /			
ADDRESS					
CITY		STATE		ZIP	
Sex M [ ] F [ ]	SS#	HEIGHT		WEIGHT	
EMAIL					

PLEASE PROVIDE NUMBERS THAT YOU MAY BE REACHED BETWEEN THE HOURS OF 8:00-5:00

Home ( )
Cell ( )

Emergency Contact Name
Emergency Contact Phone # ( )

IF PATIENT IS A MINOR OR YOU ARE THE PATIENTS GUARDIAN, COMPLETE THESE TWO LINES

Responsible Party Name		Phone#		Relation to patient	
Address/City/State/Zip					

REFERRAL INFORMATION

Referring Physician		Phone #	
Physical Therapist		Phone #	

REASON FOR VISIT

If you are here to get a brace:	
What caused you to need a brace.	
Have you ever had this type of brace before?	[ ] Yes [ ] No
If so, when?	
Where did you get it?	

If you are here to get a prosthesis	
Do you have a prosthesis now? Yes [ ] No [ ]	
Right [ ] Left [ ] Bilateral [ ]	
How old is your prosthesis?	
Surgeon who performed amputation	

VOCATIONAL INFORMATION

Employed Full Time		Employed Part Time		Homemaker		Other	

INSURANCE INFORMATION

Primary Insurance		ID #	
Policy Holder's Name		Date of Birth	
Policy Holder's Address		Relation to patient	

Secondary Insurance		ID #	
Policy Holder's Name		Date of Birth	
Policy Holder's Address		Relation to patient	

updated 7/31/17

Signature_____ Date_____