Spectrum Orthotics & Prosthetics, Inc.

Print Form

Please **PRINT LEGIBLY** and make sure you complete all information on the form.
PLEASE GIVE FRONT DESK YOUR INSURANCE CARD(S) AND PHOTO ID TO COPY FOR YOUR PATIENT FILE.

PATIENT'S FIRST NAME	MI	LAST NAME	GENDER
			◯ MALE ◯ FEMALE

MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE

E-MAIL ADDRESS	CAN WE EMAIL YOU?	REFERRING PHYSICIAN	FAMILY PHYSICIAN
	◯YES ◯ NO		

ARE YOU CURRENTLY LIVING IN AN ASSISTED LIVING/SNF?	◯YES ◯ NO	NAME OF FACILITY	

MEDICAL INFORMATION:

ARE YOU DIABETIC?	◯YES ◯ NO	IF YES, WHO TREATS YOU FOR DIABETES?	
ALLERGIES TO NEOPRENE OR LATEX?	◯YES ◯ NO	CURRENT WEIGHT	CURRENT HEIGHT
HAVE YOU PREVIOUSLY RECEIVED A BRACE, ORTHOTIC, OR PROSTHETIC?	◯YES ◯ NO	IF YES, WHAT TYPE?	DATE PROVIDED
HAVE YOU HAD ANY RECENT SURGERIES?	◯YES ◯ NO	IF YES, EXPLAIN:	
WHAT IS YOUR REASON FOR TODAY'S VISIT?			

EMERGENCY CONTACT INFORMATION:

FIRST NAME	MI	LAST NAME	CONTACT PHONE NUMBER

EMPLOYMENT INFORMATION:

NAME OF EMPLOYER	WORK TELEPHONE NUMBER

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY	CUSTOMER SERVICE NUMBER ON BACK OF CARD

ARE YOU THE INSURED?	IF NO – WHO IS THE INSURED / RELATIONSHIP	INSURED'S DATE OF BIRTH
◯YES ◯ NO		

IS THIS WORK / AUTO RELATED?	INSURANCE CARRIER	CLAIM NUMBER	ADJUSTER NAME	PHONE NUMBER
◯YES ◯ NO				

SECONDARY INSURANCE INFORMATION *Complete this section if you have other insurance coverage*:

NAME OF INSURANCE COMPANY	CUSTOMER SERVICE NUMBER ON BACK OF CARD

ARE YOU THE INSURED?	IF NO – WHO IS THE INSURED / RELATIONSHIP	INSURED'S DATE OF BIRTH
◯YES ◯ NO		

FINANCIAL POLICY AND AUTHORIZATION: I understand that I am personally responsible for payment of bills to Spectrum O&P at the time service is rendered. I hereby authorize Spectrum O&P to provide service for the above named patient when prescribed by a physician.

Signed:_____ Date:_____

Print Name of Responsible Party:_____