

# Spectrum Orthotics & Prosthetics, Inc.

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	
					<input type="radio"/> MALE <input type="radio"/> 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	
			<input type="radio"/> YES <input type="radio"/> NO			
ARE YOU CURRENTLY LIVING IN AN ASSISTED LIVING/SNF?				NAME OF FACILITY		
<input type="radio"/> YES <input type="radio"/> NO						

## MEDICAL INFORMATION:

ARE YOU DIABETIC?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, WHO TREATS YOU FOR DIABETES?			
ALLERGIES TO NEOPRENE OR LATEX?	<input type="radio"/> YES <input type="radio"/> NO	CURRENT WEIGHT		CURRENT HEIGHT	
HAVE YOU PREVIOUSLY RECEIVED A BRACE, ORTHOTIC, OR PROSTHETIC?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, WHAT TYPE?		DATE PROVIDED	
HAVE YOU HAD ANY RECENT SURGERIES?	<input type="radio"/> YES <input type="radio"/> 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	
<input type="radio"/> YES <input type="radio"/> NO					
IS THIS WORK / AUTO RELATED?	INSURANCE CARRIER	CLAIM NUMBER	ADJUSTER NAME	PHONE NUMBER	
<input type="radio"/> YES <input type="radio"/> 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	
<input type="radio"/> YES <input type="radio"/> 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: \_\_\_\_\_