Patient Intake 2024

Patient Name _____DOB _____/_____/_____

Address _____City_____State_____Zip_____

Phone#:_____Email Address _____

Weight _____ Height_____ Gender: Male ☐ Female ☐ If you are a VA patient SS# _____/_____/_____

We contact patients by phone, but you may contact me by (mark all that apply) Phone ☐ Text ☐ Email ☐

Emergency Contact (or if patient is a minor) Parent or legal Guardian

Name_____Relation:_____Phone:_____

So that we do not inadvertently share private health information with someone unauthorized, please list any persons or family members you authorize us to speak with in your behalf (for appointments, general information, billing, etc.)

Name & Relationship _____ DOB____/____/____ Phone_____

Name & Relationship _____ DOB____/____/____ Phone_____

Prescribing Doctor: _____ PT (if any)_____

Are you currently residing in a skilled nursing facility? Yes ☐ No ☐

A **skilled nursing** facility, is a temporary residence for **patients** undergoing medically necessary rehabilitation treatment.

What is your appointment for: Helmet ☐ Brace ☐ Prosthesis ☐ Shoe Insert ☐ Other ☐

If you are here for a brace, fill out this box:	If you are here for a prosthesis, fill out this box:
Left ☐ Right ☐ Both ☐ Not applicable ☐ What caused you to need the brace? _____ Have you ever had this type of brace before Yes ☐ No ☐ If yes, who provided it and when _____ _____/_____/_____	Left ☐ Right ☐ Both ☐ Not applicable ☐ Do you currently have a prosthesis? Yes ☐ No ☐ If yes, how old is it? _____ years Date of amputation _____/_____/_____ Surgeon who performed the amputation _____

Insurance Information

Primary Insurance: _____ Policy Holder's name: _____ Policy Holder's Date of Birth _____/_____/_____	Secondary Insurance: _____ Policy Holder's name: _____ Policy Holder's Date of Birth _____/_____/_____

Signature: _____ Date: _____/_____/_____