INDEPENDENCE
PROSTHETICS - ORTHOTICS, INC.

Patient Information

Patient Name: _____ **M/F** Date: _____

Date of Birth: _____ SS# _____ E-Mail Address: _____

Marital Status: S/M/D/W/Other Employed/Retired/Student/Other

Home Address: _____

_____

Home Phone: (_____) _____Cell Phone: (_____) _____ Other: (____) _____

***Is it ok to contact you by phone: YES NO** ***Is it ok to leave a message at the number(s) you provided?: YES NO**

***Is it ok to send/receive medical history to/from referring and primary care physicians? YES NO**

Insurance

Primary Insurance: _____ Policy Holder: _____ Subscriber DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Subscriber DOB: _____

Responsible Party (if patient is a minor)

Name: _____ DOB: _____

Address: _____ Relationship: _____

Is this a Workman's Comp or Auto Accident Claim? YES NO

For Workman's Comp or Auto Accident only:

Insurance Name: _____ Accident Date& State: _____Claim #: _____

Contact Person: _____ Phone Number: _____

Claims Address: _____

Emergency Contact

Name: _____ Phone: _____

***Is it okay to discuss personal information with your emergency contact? YES NO**

Patient or Guardian's Signature: _____ Date:_____