

PATIENT INFORMATION

For Office Use Only



Patient Information:

Name: _____
(LAST) (FIRST) (MIDDLE INITIAL)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ E-Mail: _____

Date of Birth: ___/___/___ Gender: Male Female Social Security # _____

Patient Status: Single Married Other Occupation: _____

Employer's Name: _____

Employer's Address: _____

Emergency Contact: _____
(NAME)

(ADDRESS) (PHONE)

Responsible Party:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: ___/___/___ Gender: Male Female Social Security #: _____

Relationship to Patient: _____

Employer's Address: _____

Primary Insurance Information:

Insurance Company Name: _____ Policy ID#: _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Holder: _____ DOB: _____ Relationship: _____

Secondary Insurance Information:

Insurance Company Name: _____ Policy ID#: _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Phone: _____

Policy Holder: _____ DOB: _____ Relationship: _____

(OVER)

Worker's Compensation:

Name of Insurance Company: _____

Address: _____

Contact or Claim # _____ Contact: _____

Phone: _____ Date of Accident: _____ State where accident occurred: _____

If Worker's Comp claim, name of employer at time of accident: _____

Details of Accident/Injury: _____

Health Information:

Height: _____ Weight: _____ Diabetic: Yes No

If Diabetic, name of physician treating your condition: _____

Accident: _____ State where accident occurred: _____ Date of Accident: _____

Details of Accident: _____

Amputations: _____ Dates of Amputation: _____

Reason: _____

Surgeries related to your visit: _____

Other medical professionals have you seen relating to your visit (Primary Care Physician, Endocrinologist, Surgeon, etc.): _____

Have you had or do you have any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Alzheimer Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Obesity | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pulmonary Disease (TB) | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Known Allergies | | |

If yes, please list: _____

List any other conditions that you feel might affect your treatment: _____

Patient Signature:

I verify the accuracy of the above information. Patient should realize that professional services are provided to the person, not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to Virginia Prosthetics, Inc. We cannot render services on the assumption that the charges will be paid by insurance company.

I have read and understand that Virginia Prosthetics, Inc. may bill my insurance company but this DOES NOT GUARANTEE BENEFITS. I understand that Virginia Prosthetics, Inc. will bill me directly for all supplies and services not covered by insurance. I understand that these supplies are not returnable once I have removed them from the premises.

_____ Date: _____