Date: _____

Comfort Prosthetics & Orthotics Patient Intake Form

We'd like to welcome you as a new patient. Please take a few minutes to fill out these forms as accurately as possible so we can most appropriately address your needs.

The confidentiality of your health information is protected in accordance with federal regulations for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Please print all responses and bring these forms to your next appointment.

Name: _____ Date of Birth: _____

Address: _____

_____

Drivers License #_____ Social Security # _____

Sex:_____ Race (eg, African-American, Latino, Asian, etc):_____

Home Tel (____) ____ - _____ Work Tel (____) ____ - _____ Cell (____) ____ - _____

Email Address: _____

Emergency Contact:_____ Emergency Phone: (____) ____ - _____

Primary Care Physician:_____ Physician Phone: (____) ____ - _____

Physician Address:_____

Physician NPI (for office only):_____

Referring Physician:_____ Physician Phone: (____) ____ - _____

Physician Address:_____

Physician NPI (for office only):_____

Primary Insurance Information

Person Responsible for Account:_____
Last First M.I.

Relationship to Patient:_____Birth date:_____SSN:_____

Address *(if different from patient)*:_____ Phone: _____
City: _____ State:_____ Zipcode: _____

Employer: _____ Occupation: _____

Insurance Company: _____

Insurance Policy Number: _____

Insurance ID Number: _____

Secondary Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Person Responsible for Account:_____
Last First M.I.

Relationship to Patient:_____Birth date:_____SSN:_____

Address *(if different from patient)*:_____ Phone: _____
City: _____ State:_____ Zipcode: _____

Insurance Company _____

Insurance Policy Number: _____

Insurance ID Number: _____

Assignment and Release

I, the undersigned, certify that all of the above insurance information is accurate and assign directly to Comfort Prosthetics & Orthotics all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the release of all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Medical History

Indicate which of the following you have experienced or are currently experiencing:

❑ Heart surgery/disease/attack	❑Kidney/Liver disease	❑ Paralysis/Stroke
❑ Diabetes	❑Seizure	❑ Blood Clotting disorder
❑ Lung/Respiratory problems	❑Cancer	❑ Neurologic disorder
❑ PVD	❑Balance problems	❑ Allergies
❑ Sores/Open Wounds	❑Osteomyelitis	❑Depression

If you checked any of these conditions, or are experiencing others, please indicate the specific nature here:

_____

_____

_____

Current Medical Status

Height: _____ Weight: _____ Amputation Level:_____ (AK,BK, AE, BE, etc.)

Amputation Cause _____ Amputation Date:_____

Affected Side:_____(R, L, BLT) Shoe Size:_____ Liner Size _____

Are you diabetic? Yes No

Please list current medications and dosages: _____

_____

_____

_____

Is this your first prosthetic? Yes No If No, how long have you worn a prosthesis? _____

Are you experiencing problems with your current prosthesis? _____

_____

_____

Date of last X-Ray:_____ Date of last CT scan:_____

Additional surgeries:

_____

_____

Ambulatory Goals / Daily Activities / Other Significant Information:

_____

_____

_____

Patient Signature: _____

Photo Release Authorization

I, _____, give /do not give Comfort Prosthetics & Orthotics permission to take photographs/videotape of my prosthetic or myself. These photographs may be used for insurance verification and claims, or used for marketing purposes (our websites, brochures, mailers, commercials) or appear within the Comfort Prosthetics & Orthotics facilities in different displays.

Medical Records Release AuthorIzatIon

Client Name _____ Address _____
DOB: _____

I, _____ , hereby authorize the following _____
(name of provider/plan, e.g. doctor, insurance)

To disclose from the records of the above named client to:
Comfort Prosthetics & Orthotics
276 SB Gratiot 140 S Main St
Mount Clemens Yale
MI 48043 MI 48097

For the specific purpose of PROSTHETIC/ORTHOTIC EVALUATION AND TREATMENT.
"All medical records" includes any and all written information you may have concerning my health care and any illness or injury that I may have suffered, including but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital records pertaining to me.

This authorization is valid for the purpose of time needed to fulfill its purpose for up to three years, except for disclosures of financial transactions, wherein the authorization is valid indefinitely.

I understand that I can revoke this authorization at any time with written notification. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding

I also understand that I may refuse to sign this authorization, and will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. However, if a service is requested by a non-treatment provider (i.e. insurance company), for the sole purpose of creating health information (e.g. physical exam), service may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization; a copy of this authorization shall be as binding as the original.

Signature of Client/ Guardian)_____Date_____
Relationship to client_____