Patriot Prosthetics and Orthotics, Inc.

1804 Commons Circle, Suite A, Yukon, OK 73099
(405) 577-6778 office (405) 577-6799 fax
patriotprosthetics@yahoo.com

PATIENT INFORMATION
(Please Print Clearly-Line above)

First Name Middle Name Last Name Date of Birth Male____Female____

Address City State Zip

Social Security Number Home Phone Cell Phone Work Phone

Height Weight Shoes Size Are You Diabetic Any Known Allergies (Chemical or Materials)

Email Address Employers Name (or Guardians Employer)

Emergency Contact (Print Full Name) Phone Number HM CELL WK (Circle One) Relationship to Patient

Reason for Today's Visit What Side? Right Left Bilateral

Have you seen your Physician for an exam regarding this Prescription and/or Condition? (Insurance Requirement)

Name of Prescribing Physician (The Physician who signed your prescription for today's visit) Is this your PCP?

Prescribing Physicians Phone Number Address City State Zip

Primary Care Physician Name Phone Number Address City State Zip

Workers Comp? If yes, please provide Case Manager Name Phone Number Case Number

If Patient is Under the Age of 18 (Minor) Printed Full Name of Legally Responsible Party/Guardian

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Relationship to Patient Daytime Phone Numbers Home Cell Work

Responsible Party/Guardians Address City State Zip

Primary Insurance Company Effective Date Member ID Number

Policy Carriers Full Name Date of Birth

If Member ID is SS# of Carrier Please provide Carriers SS# Carriers Employer Name

Policy Carriers Address and Daytime Phone Number

Secondary Insurance Company Effective Date Member ID Number

Policy Carriers Full Name Date of Birth

If Member ID is SS# of Carrier Please provide Carriers SS# Carriers Employer Name

Policy Carriers Address and Daytime Phone Number

Has patient ever had this type of device or similar in the past? If yes, What Type?

Company / Practitioner Purchased From? Date of Purchase

Has patient had any falls in the last 6 months? Any visits to ER, Hospital or Urgent Care in the last 6 months?

What are the patient's daily activities?

Is patient active? Does patient use any assistive devices during ambulation? How often per day?

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Is this condition from an Accident from Employment? Auto Accident? Other Accident?

If answer is yes to any of the above, please provide date of accident and description

Has patient had this condition since birth? Please describe Diagnosis

Is patient in Physical Therapy, Occupational Therapy, Speech Therapy?

Any other issues you would like to describe or make the Practitioner aware?

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PLEASE INITIAL THE FOLLOWING:

__________________The products and/or services provided to you by supplier Patriot Prosthetics and Orthotics, Inc. are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained from the U.S. Government Printing Office website. Upon request we will furnish you a written copy of the standards.

___________________You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations.

If you would like to place any restrictions, please do so here____

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___________________I have read and understand the documentation requirements for any device(s) I receive from Patriot Prosthetics and Orthotics, Inc. and that this documentation must be accurate, complete and obtained by Patriot Prosthetics and Orthotics, Inc*.* ***before*** the delivery of any prescribed device(s).

___________________ As a courtesy, we are happy to check your insurance for coverage and find out an ESTIMATED FINANCIAL RESPONSIBILITY for the services we are providing to you or your loved one. However, ultimately, Payment for all services provided by Patriot Prosthetics and Orthotics, Inc. is the responsibility of the patient. It is up to you to understand what your policy and contracted coverage is with your insurance company. It is also very important that you know how much you have for an individual deductible and a family deductible and if your deductible has been met and/or how much is remaining. This is all determined by the date of delivery of your product and not the first day being seen. We only bill for your product after the date of delivery.

I have read and understand that I am ultimately financially responsible for any services rendered to myself, my child or anyone I may have guardianship over.

By signing this I am acknowledging that I will be financially responsible for the entire amount of the device(s) and services rendered by Patriot Prosthetics and Orthotics, Inc.

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Signature of Patient, Responsible Party, Guardian Date of Signature