LAWALL

Prosthetics & Orthotics Services

PATIENT INFORMATION SHEET

Site: _____ Account: _____ Date: _____

Patient Name: _____ Date of Birth:_____ Sex:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ E-Mail: _____

Height: _____ Weight: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Relationship:_____

Home Address: _____Home Phone #:_____

PHYSICIAN INFORMATION:

Referring Physician:_____ Phone number:_____

Primary Care Physician:_____ Phone Number: _____

MEDICAL DEVICE HISTORY:

Have you ever received an orthotic or prosthetic device? Yes ☐ NO ☐

If Yes: When: _____ Please describe the device: _____

Date of Injury:_____ Date of Surgery:_____

Do you have known allergies to Latex, wool or other materials? Yes ☐ NO ☐

If yes, please specify: _____

Is this related to a work injury: Yes ☐ NO ☐. If yes notify receptionist.

Is this related to an auto injury: Yes ☐ NO ☐. If yes notify receptionist.

RESPONSIBLE PARTY:

NAME:_____ ADDRESS:_____

PHONE #: _____ WORK #: _____

RELATIONSHIP TO PATIENT: _____ DOB:_____

INSURANCE INFORMATION:

Primary Insurance:_____

Phone #: _____ Policy #:_____

If patient is considered a child or spouse on the insurance plan please complete the following:

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Relation to Patient:_____

Secondary Insurance: _____

Phone #: _____ Policy #:_____

If patient is considered a child or spouse on the insurance plan please complete the following:

Subscriber's Name:_____ Subscriber's Date of Birth:_____

Relation to Patient:_____

Assignment of Benefits / Authority for Release of Information:

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Lawall for any covered services furnished to me by this facility. I authorize the release of any information necessary to provide services or process claims. Even though your insurance company authorizes services, an authorization is not a guarantee of payment. As the responsible party I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent. I agree to notify Lawall immediately of any change in insurance coverage or status. The date of service that will be billed to your insurance company is the date the device is received.

_____ _____

Patient or Responsible Party Signature Date

I certify that I have received a copy of Lawall's notice of privacy practices.

_____ _____

Patient or Responsible Party Signature Date