LAWALL 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:

Primary Care Physician:_____ Phone Number: _____

When was your last appointment with your Primary Care Physician?_____

Referring Physician:_____ Phone number:_____

When was your last appointment with your Referring Physician?_____

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 Harry J. Lawall & Son, Inc., 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 Harry J. Lawall & Son, Inc. 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.**

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

_____ _____

Patient or Responsible Party Signature Date