

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