A Specialized Approach to Prosthetics, Inc.
500 Spring Hill Drive Suite 200
Spring, Tx 77386

PATIENT INFORMATION FORM

PATIENT NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

EMERGENCY CONTACT: _____ RELATION: _____ Phone #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

1. _____ ID #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE

1. _____ ID #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

BACKGROUND INFORMATION

AFFECTED SIDE: (circle) AGE: _____ SEX: _____

Left Right Bi-lateral ETHNICITY: _____

AFFECTED LEVEL: (circle) PRIMARY LANGUAGE: _____

Lower Extremity (AK) (BK) Upper Extremity (AE) (BE) HEIGHT: _____ WEIGHT: _____

Do you currently wear a device? _____ SHOE SIZE: _____

If yes, when did you receive it? _____

REFERRING PHYSICIAN

Referring Physician: _____ Phone #: _____ Fax: _____

Primary Care Physician: _____ Phone #: _____ Fax: _____

HOW DID YOU HEAR ABOUT US?

_____ Physician _____Hospital _____Physical Therapist _____Nurse _____Case Manager

_____ Friend _____Relative _____Insurance Comp _____Sales Rep _____Other

I certify all of the above information is correct and true to the best of my knowledge.

_____ _____

Patient (or Parent/Guardian) Signature Date

_____ _____

Representative (if patient is unable to sign) Date