Orthotic & Prosthetic Lab, Inc.

(This information is necessary for our files and will be considered confidential) Pt ID#: _____

Patient's Full Name _____Date _____
Address _____City _____ State _____ Zip _____
Sex M / F Birthdate _____ E Mail Address _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Social Security # _____ Marital Status: Minor/Single/Married/Widowed/Divorced
If under 18, guardian name _____
Guardian SS# _____ Guardian's date of birth: _____
*Emergency Contact _____ Phone # (___)_____

Referring Physician _____ Diagnosis/Nature of Injury _____
Primary Care Physician _____

Are you a diabetic? Y / N Do you take insulin? Y / N Name of diabetic Dr: _____
Do you have a history of any of the following symptoms (circle all that apply): amputation, foot ulcerations, callus, peripheral neuropathy, foot deformity or poor circulation

PRIMARY INSURANCE

Name of Insured _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Home Phone # _____ Cell # _____
Relationship to Patient: Self /Spouse/Parent/Other Name of Insurance_____
Insurance ID# _____ Ins. Group # _____
Place of Employment _____ Employer Phone # _____

SECONDARY INSURANCE

Name of Insured _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Home Phone # _____ Cell # _____
Relationship to Patient: Self /Spouse/Parnt /Other Name of Insurance_____
Insurance ID# _____ Ins. Group # _____
Place of Employment _____ Employer Phone # _____

WORKERS' COMPENSATION

Employer at time of injury _____Phone # (____)_____ Date of Injury _____
Workers' Comp. Insurance Name _____
Phone # (___)_____ Claim # _____ Case Manager _____

AUTOMOBILE ACCIDENT

Insurance Company or Agency Name _____
Claim/Case # _____ Date of Accident _____
Insurance Contact _____ Phone # (___)_____