UNITY PROSTHETICS AND ORTHOTICS

PATIENT INTAKE FORM

PATIENT INFORMATION Date _____

Patient Name: First: _____Middle Initial: ____ Last: _____

Social Security #: _____ - ____ - _____ DOB: _____ - _____ - _____ ☐ Male ☐ Female

Phone: _____ Work: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: ___ Zip: _____

Responsible Party

(Check one): ☐ The responsible party listed above ☐ is different than above

Full Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Social Security #: _____ - ____ - _____ DOB: _____ - _____ - _____

Phone: _____ Work: _____ Cell: _____

Email: _____

Medical Professionals Involved In Your Care

☐ Prescribing Physician: _____ Phone: _____

☐ Primary Care Physician: _____ Phone: _____

☐ Other: _____ Phone: _____

Insurance Information

Please provide a copy of your photo ID, all insurance cards, and any prescriptions that you have.

Primary Insurance: _____ Policy ID: _____ Group: _____

Secondary Insurance: _____ Policy ID: _____ Group: _____

Is the policy holder someone other than the patient: ☐ Spouse ☐ Dependent ☐ Not Related

First: _____ Middle Initial: _____ Last: _____

DOB: _____ - _____ - _____ Social Security: _____ - _____ - _____

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PATIENT INTAKE FORM

May we phone, email, or send a text to you to confirm appointments?

☐ Yes ☐ No

May we leave a message on your answering machine at home or on cell phone?

☐ Yes ☐ No

May we discuss your medical condition with any other person?

☐ Yes ☐ No (if yes please name the authorized person) _____

_____

☐ By checking this box, you authorize Unity Prosthetics and Orthotics to leave detailed phone messages for you, which may include private healthcare information.

☐ By checking this box, you authorize Unity Prosthetics and Orthotics to utilize email and text messaging as a form of communication with you. Our communications only include information regarding your treatment plan, updates, and our services.

Verification of Information Accuracy

I verify that, to the best of my knowledge, the information I have provided in this form is accurate.

Patient Signature: _____ Date: _____