**PATIENT INFORMATION**

***For Office Use Only***


## Patient Information:

**Name:**_____
(LAST) (FIRST) (MIDDLE INITIAL)

**Address:**_____

**City:**_____ **State:**_____ **Zip:**_____

**Home Phone :**_____ **Work Phone:**_____

**Cell Phone :** _____ **E-Mail:**_____

**Date of Birth:** ____/____/____ **Gender:** ☐ **Male** ☐ **Female** **Social Security #**_____

**Patient Status:** ☐ **Single** ☐ **Married** ☐ **Other** ☐ **Widowed** **Occupation:** _____

**Employer's Name:** _____ **Address:** _____

**Emergency Contact:** _____
(NAME)

_____
(ADDRESS) (PHONE)

## Responsible Party:

**Name:**_____

**Address:**_____

**City:**_____ **State:**_____ **Zip:**_____

**Home Phone:**_____ **Work Phone:**_____

**Date of Birth:** ____/____/____ **Gender:** ☐ **Male** ☐ **Female** **Social Security #:**_____

**Relationship to Patient:**_____

**Employer's Address:**_____

## Primary Insurance Information:

**Insurance Company Name:**_____**Policy ID#:**_____

**Policy Holder:**_____**DOB:**_____**Relationship:**_____

## Secondary Insurance Information:

**Insurance Company Name:**_____**Policy ID#:**_____

**Policy Holder:**_____**DOB:**_____**Relationship:**_____

## PHI Disclosure Authorization

**I authorize disclosure of my Protected Health Information (PHI) regarding my billing, condition, treatment, and prognosis to the following individuals:**

_____ _____

_____ _____

**This medical information may be used by the person(s) I authorize to receive this information for treatment and prognosis, billing or claims payment, or other purposes as I may direct.**

_____ **Date:** _____

**(Patient or Authortized Signature)**

## Worker's Compensation:

**Name of Insurance Company:**_____

**Address:**_____

**Contact or Claim #**_____ **Contact:**_____
**Phone:**_____ **Date of Accident:**_____**State where accident occurred:**_____

**If Worker's Comp claim, name of employer at time of accident:**_____

**Details of Accident/Injury:**_____

_____

## Health Information:

**Height:**_____ **Weight:**_____**Diabetic:** ☐ **Yes** ☐ **No**

**If Diabetic, name of physician treating your condition:**_____
**Accident:**_____ **State where accident occurred:**_____ **Date of Accident:**_____
**Details of Accident:**_____
**Amputations:**_____ **Dates of Amputation:**_____
**Reason:**_____
**Surgeries related to your visit:**_____
**Other medical professionals have you seen relating to your visit (Primary Care Physician, Endocrinologist, Surgeon, etc.):** _____
**Have you had or do you have any of the following:**

| | | |
|---|---|---|
| ☐ **Heart Problems** | ☐ **Hepatitis C** | ☐ **Alzheimer Disease** |
| ☐ **Hypertension** | ☐ **HIV Positive** | ☐ **Pacemaker/Defibrillator** |
| ☐ **Vascular Disease** | ☐ **Rheumatoid Arthritis** | ☐ **Seizure Disorder** |
| ☐ **Stroke** | ☐ **Obesity** | ☐ **Hearing Loss** |
| ☐ **Diabetes** | ☐ **Osteoarthritis** | ☐ **Currently Pregnant** |
| ☐ **Kidney Disease** | ☐ **Pulmonary Disease (TB)** | ☐ **MRSA** |
| ☐ **Osteoporosis** | ☐ **Vision Problems** | ☐ **Parkinson Disease** |
| ☐ **Known Allergies** | | |

**If yes, please list:**_____
**List any other conditions that you feel might affect your treatment:**_____

_____

### Patient Signature:

**I verify the accuracy of the above information. Patient should realize that professional services are provided to the person, not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to Virginia Prosthetics, Inc. We cannot render services on the assumption that the charges will be paid by insurance company.**

**I have read and understand that Virginia Prosthetics, Inc. may bill my insurance company but this DOES NOT GUARANTEE BENEFITS. I understand that Virginia Prosthetics, Inc. will bill me directly for all supplies and services not covered by insurance. I understand that these supplies are not returnable once I have removed them from the premises.**

_____ **Date:**_____

(PATIENT OR AUTHORIZED SIGNATURE)