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**
Primary Care Physician: _____
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 (Endocrinologist, Surgeon, etc.): _____
Have you had or do you have any of the following:

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

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)