Patient Height and Weight: _____

Streamline ORTHOTICS + PROSTHETICS

PATIENT INFORMATION

Name: (Last, First, MI) _____ Date of Birth: ____/____/____

Social Security #_____ Weight: _____lbs. Gender: ☐ M ☐ F
Street Address _____ Apartment # _____
City: _____ State: _____ Zip Code: _____
Phone _____ _____ _____
(primary) *(secondary)* *(tertiary)*

☐ Consent to contact you at all numbers listed above and leave a message regarding my orthotic/prosthetic needs

Email: _____
Guardian (financially responsible person) Name: _____ Phone _____
Referring Physician/Pediatrician Name: _____ Phone _____

INSURANCE POLICIES

Primary Insurance: _____ Policy ID# _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Secondary Insurance: _____ Policy ID# _____

Policy Holder Name: _____ Date of Birth: ____/____/____

FIRST STEPS PATIENTS ONLY

Referring Diagnosis and Type of Orthotic Requested: _____
Coordinator Name and Meeting Date: _____
Referring Therapist Name and Phone Number: _____
Please list requested therapy visit dates and we will contact the therapist to coordinate the evaluation when possible:

_____

_____

IS THIS VISIT RELATED TO WORKER'S COMPENSATION INJURY? ☐ YES ☐ NO
*If yes, please ask our office for our Worker's Compensation Form to include the necessary information.

Benefits, Medical Information Release Authorization and Acknowledgement of Financial Responsibility:
I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information. I request my insurance benefits, if any, be paid directly to the provider. I authorize the release of any information necessary to provide services or process claims. As the responsible party, I understand that I am personally responsible for the entire amount of my claim and that insurance benefits may be limited or non-existent.

_____ _____
Signature of Patient or Guardian/ Authorized Representative *Date*

_____ _____
Printed Name of Above *Relationship to patient*