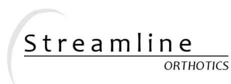

PATIENT INTAKE FORM

Patient Name (Last, First, MI) ____

Social Security # ______________________Date of Birth _______________ Sex: Male ______ Female________

Permanent Address ____

City ____ State _______________ Zip __________________

Home phone (______) __________________________Work phone (______) _____________________________

Employer Name and address ____

Primary Insurance

Insurance Company Name ____

Group Name/Number ______________________________ ID#____

Subscriber's Name (Last, First, MI) ____

Social Security # ______________ Date of Birth _______________Relationship to Patient __________________

Employer Name and Address ____

Secondary Insurance

Insurance Company Name ____

Group Name/Number ______________________________ ID#____

Subscriber's Name (Last, First, MI) ____

Social Security # ______________ Date of Birth _______________Relationship to Patient __________________

Employer Name and Address ____

If injury is work-related, please answer the following:

Employer at time of Injury____ Date of Injury______________

Employer Address ____ Phone# (_____)____________________

Workers' Comp Insurance Name & Address____

Name of Case Manager_______________________ Phone# (_____)___________________Claim #___________

Have you ever had a similar device to the device you will be receiving from us? Yes ______No _______

If yes, when did you receive this device? Month /Year _____________ Do you still have the device? _______

How was this device paid for? _____ Medicare ______ Self-pay _______ Received in hospital

____ Insurance (If so, which insurance company? ___________________________________)

Are you currently staying in a Medicare-covered bed at a skilled nursing facility? Yes ______No _______

How did you hear about Streamline Orthotics, LLC? ____

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.

____ _____________________________

Signature of Patient Date

____ _____________________________

Signature of Parent/Guardian/Authorized Representative Relationship to patient