orthocare solutions

PATIENT INTAKE FORM

Patient Name (Last, First, MI) _____

Social Security # _____ Date of Birth _____ Sex: Male _____ Female_____

Permanent Address _____

City _____ State _____ Zip _____

Cell Phone (_____) _____ Home Phone (_____) _____

Work Phone (_____) _____ Employer Name _____

Employer 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 _____ Claim #_____

Address_____

Name of Case Manager_____ Phone# (_____) _____

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 ORTHOCARE SOLUTIONS? _____

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**