PPS Orthotic & Prosthetic Services

Patient Information

Please Print All Information Date:_____/_____/_____

Patient Last Name: ___________________ First: _______________ Middle:____________

Date of Birth:_____/_____/_____ Gender: M F Social Sec#: _________________

Email Address: ____________________________ Driver's Lic#:_____________________

Vocational Category: (please circle) Full Time Part Time

Employed Student Homemaker Disability Unemployed Retired

Marital Status: (please circle) Single Married Divorced Widowed Child

Home Phone: ______________ Work Phone: _____________ Cell Phone: ______________

Home Address Street:____

City: ___________________________ State: _____ Zip: ________

Employer or School Name: ____

Name of Responsible Party: ____

Address: ____________________________________ Phone: _________________

Emergency Contact Name: ____

Address: ____________________________________ Phone: _________________

Relationship to Patient: ______________________________

Referring Physician: _________________________________ Phone: __________________

Primary Physician: __________________________________ Phone: __________________

Physical Therapist: __________________________________ Phone: __________________

Who referred you? ____

In most instances, we will bill your insurance for payment of our services. However, we do request payment for certain orthotic devices at the time of delivery. We will provide you with the necessary paperwork to file with your insurance company. Your coverage is a contract between you and your insurance carrier. You are responsible for your entire balance in circumstances where your insurance company denies coverage, as well as any remaining balance after insurance has paid. If this matter is turned over for collection, you will be responsible for all collection fees and attorney/court costs incurred. Your signature below indicates your understanding and agreement to accept responsibility for any and all charges incurred through this office and to allow us to release any private health information to file claims with your insurance carrier.
I acknowledge that I have received or had access to Medicare Supplier Standards, HIPAA Privacy Laws, and Patient Rights and Responsibilities.

Signature of Responsible Person:___________________________ Date:_____/_____/_____

Primary Insurance Information

Is this a Worker's Comp Case? (Circle) Yes No

Primary Insurance Company: ____

Street: ____

City: ________________________________ State: _______ Zip: ____________

Phone: ________________________________

ID #: ________________________________ Group #: _____________________

Relationship to Insured: (Circle) Self Spouse Other

Insured's Name: _______________________ Effective Date: _____________

Insured's Date of Birth: __________ Insured's Soc Sec #: ________________

Check if Copy of Card has been Provided

Secondary Insurance Information

Secondary Insurance Company: ______________________________________

Street: ____

City: _________________________________ State: ______ Zip: ____________

Phone: _________________________________

ID #: _______________________________ Group #: ______________________

Relationship to Insured: (Circle) Self Spouse Other

Insured's Name: _______________________ Effective Date: _____________

Insured's Date of Birth: __________ Insured's Soc Sec #: ________________

Check if Copy of Card has been Provided

Patient Medical History

Reason for Visit: ____

Diagnosis for Visit: ______________________________________

Is your condition a result of an accident? Work Auto Other

Date of Accident: ____/____/____ State of Accident: ______

Type of Accident: _______________________________________

General Health: Poor Fair Good Excellent

Activity Level: Low Med Active Highly Active

Height: ______ Weight: ______ Shoe Size: _______

Have you received any orthotics or prosthetics within the past 5 years?

Yes No If yes, please list item and date: ___________________

____

Description of Past Surgeries	Date
____	____/____/____
____	____/____/____
____	____/____/____

Please indicate your current medical conditions:

Heart Problems	Hepatitis A or B	Parkinson Disease
Hypertension	HIV Positive	Alzheimer Disease
Vascular Disease	Rheumatoid Arthritis	Psychiatric Problems
Stroke	Obesity	Alcoholism
Diabetes	Pulmonary Disease	
Kidney Disease	Vision Problems	

Allergies: ____

Medications you are currently taking: _______________________________