PATIENT INFORMATION

NAME: ____

DATE OF BIRTH: ___________________________ **SOCIAL SEC #:** ____________________________

HEIGHT: _________________ **WEIGHT**: _________________ **SHOE SIZE**: ______________

MARITAL STATUS: SINGLE / MARRIED / OTHER **SEX**: MALE / FEMALE

ADDRESS: ____

____

CELL #: ____________________ **WORK #**: ____________________ **HOME #**: ___________________

BEST NUMBER TO REACH YOU: CELL ______ WORK ______ HOME ______

MAY WE LEAVE A MESSAGE? YES / NO **MAY WE CONTACT YOU BY EMAIL?** YES / NO

EMAIL ADDRESS: ____

HOW DID YOU HEAR ABOUT US? ____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN: __________________________________ **PH #:** _____________________

PRIMARY CARE PHYSICAN: _____________________________ **PH #**: ________________________

SURGEON (IF APPLICABLE): ______________________________ **PH #**: ______________________

INSURANCE AND BILLING INFORMATION

1. **PRIMARY INSURANCE**: ______________________________ **POLICY #**: ______________________

GROUP #: ______________________ **EMPLOYER**: ____

SUBSCRIBER: ____________________________________ **DATE OF BIRTH**: ______________________

RELATIONSHIP TO SUBSCRIBER: SELF / PARENT / CHILD / SPOUSE / OTHER

2. **SECONDARY INSURANCE**: ____________________________ **POLICY #**: ____________________

GROUP #: ______________________ **EMPLOYER**: ____

SUBSCRIBER: ____________________________________ **DATE OF BIRTH**: ______________________

RELATIONSHIP TO SUBSCRIBER: SELF / PARENT / CHILD / SPOUSE / OTHER

3. **DO YOU HAVE ANY OTHER INSURANCE THAT YOU WANT US TO LIST?** YES / NO

NAME OF OTHER INSURANCE CARRIER & POLICY #: ____________________________________

IS CONDITION THE RESULT OF AN ACCIDENT? YES / NO **DATE OF INJURY**: _____________

ADJUSTER: _____________________________________ **PHONE #**: ______________________________

I UNDERSTAND THAT OPC WILL MAKE EVERY REASONABLE EFFORT TO BILL ALL OF MY INSURANCE COMPANIES FOR PAYMENT ON MY ACCOUNT. I UNDERSTAND THAT ANY REMAINING BALANCE IS MY RESPONSIBILITY. IN THE EVENT THAT MY ACCOUNT IS PLACED WITH AN OUTSIDE COLLECTION AGENCY DUE TO NON-PAYMENT, I WILL BE RESPONSIBLE FOR ANY COLLECTION FEES THAT MAY BE ADDED TO MY OUTSTANDING BALANCE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR ORTHER INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY ASSIGN ALL MEDICAL BENEFITS INCLUDING MAJOR MEDICAL, OTHER GOVERNMENT SPONSORED PROGRAMS, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO THE ORTHOTIC & PROSTHETIC CENTER OF ST. PETERSBURG, INC.

PATIENT SIGNATURE: ____

DATE: __________________________________

PATIENT MEDICAL HISTORY

HAVE YOU RECEIVED A SIMILAR ITEM WITHIN THE PAST 5 YEARS? YES / NO

IF YES, APPROXIMATELY WHEN DID YOU RECEIVE IT? ________________________________

ARE YOU CURRENTLY AN INPATIENT OF A NURSING HOME OR REHAB FACILITY?

YES / NO

DO ANY OF THE FOLLOWING CONDITIONS APPLY TO YOU:

☐ HEART PROBLEMS	☐ VASCULAR DISEASE	☐ DIABETES 1	☐ DIABETES 2
☐ HEPATITIS A OR B	☐ HEPATITIS C	☐ HIV POSITIVE	☐ ALZHEIMER DISEASE
☐ ALCOHOLISM	☐ PACEMAKER	☐ HEARING LOSS	☐ MRSA
☐ HYPERTENSION	☐ STROKE	☐ KIDNEY DISEASE	☐ VISION PROBLEMS
☐ RHEUMATOID ARTHRITIS	☐ OSTEOARTHRITIS	☐ OSTEOPOROSIS	☐ PARKINSON DISEASE
☐ PSYCHIATRIC	☐ SEIZURES	☐ PREGNANT	☐ PULMONARY DISEASE

ARE YOU ALLERGIC TO LATEX? YES / NO

LIST ANY KNOWN ALLERGIES: ________________________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO

IF YES, PLEASE LIST: ________________________________

____

PATIENT CONSENT TO RECEIVE MAIL, E-MAILS, AND/OR TELEPHONE MESSAGES

EMERGENCY CONTACT: ____

RELATIONSHIP TO PATIENT: ______________________ **PHONE #**: __________________________

MAY WE LEAVE A MESSAGE? YES / NO

ORTHOTIC & PROSTHETIC CENTERS HAS MY PERMISSION TO LEAVE THE FOLLOWING INFORMATION:

	CELL	WORK	HOME
APPOINTMENT INFORMATION	*YES / NO*	*YES / NO*	*YES / NO*
BILLING INFORMATION	*YES / NO*	*YES / NO*	*YES / NO*
MEDICAL INFORMATION	*YES / NO*	*YES / NO*	*YES / NO*

I GIVE PERMISSION TO SHARE THE FOLLOWING INFORMATION WITH THE PERSON(S) LISTED BELOW:

APPOINTMENT: ____

BILLING: ____

MEDICAL: ____

PRINTED NAME: ____

PATIENT SIGNATURE: ____

DATE: __________________________