Print Form

FAMILY ORTHOTICS & PROSTHETICS
"No One Serves You Better Than Family"

PO Box 1510
Kearney, NE 68848-1510
(866) 338-3550

PATIENT INFORMATION PLEASE PRINT

Patient Name _____ **Date of Birth** _____

Social Security # _____ **Male** _____ **Female** _____

If Patient is Minor-Parents Name _____

Patient Home Address _____

City _____ **State** _____ **Zip** _____ **County** _____

Home Phone (____) _____ **Patient Cell Phone (____)** _____

Marital Status: Married _____ **Single** _____ **Divorced** ____ **Widowed** ____ **Other** _____

Patient Email Address _____

Can We Contact You by Email? Yes _____ **No** _____

Spouse Name _____ **Spouse DOB:** _____

Spouse Home Phone (_____) _____ **Cell Phone (_____)** _____

Spouses Address _____ **City** _____ **State** _____ **Zip** _____

Employer (of Patient or Parents) _____

Employer Phone (____) _____ **Address** _____

City _____ **State** _____ **Zip** _____

Emergency Contact other than Spouse: Name _____

Phone Number(s) (___) _____ **Relationship to Patient** _____

Primary Physician _____

Referring Physician _____

How did you hear about Family O & P? _____

Nature of Injury _____ **Date of Injury** _____

Is injury related to: Work____ Auto ____ Other Accident ____ Non-Acc. _____

Employer at time of accident _____

Employer Address and Phone _____ **(___)** _____

Please mark N/A for the questions that do not apply to your situation. Thank you.

- **How long have you worn orthotic shoes or inserts?** _____
- **How long have you worn diabetic shoes and inserts?** _____
- **Have you received shoes and inserts from another medical supplier and if so who and when?** _____
- **Have you received orthotic or prosthetic devices from another medical supplier and if so who and when?** _____
- **How long have you worn your prosthetic limb or mastectomy product?** _____

_____

- **Chief complaint and when did it occur?** _____

INSURANCE INFORMATION

Primary Insurance _____
Address _____
Policy# _____
Group Name/# _____
Insured's Name _____
Insured Employer _____

Secondary Insurance _____
Address _____
Policy# _____
Group Name/# _____
Insured's Name _____
Insured Employer _____

Other Insurance _____
Address _____
Policy# _____
Group Name/# _____
Insured's Name _____
Insured Employer _____
Nurse Case Manager or Adjustor for Workers Compensation claims: _____

_____

PHOTO DELIVERY RELEASE/STATEMENT

I hereby certify that the attached photo or any applicable photos taken by Family Orthotics & Prosthetics, Inc. will be used solely for submission to insurance company upon their request. Family Orthotics & Prosthetics, Inc. will not use your photo for any advertisement or marketing. Photos of services rendered can be used for training and seminars.

ASSIGNMENT OF BENEFITS/AUTHORITY FOR RELEASE OF INFORMATION

I request that payment of authorized Medicare, Medicaid or private insurance benefits be made to Family Orthotics & Prosthetics for any covered services furnished to me by Family Orthotics & Prosthetics. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, Champus and its agents or to any private insurance company any information needed to determine these benefits or the benefits payable for related services. If this is a private insurance claim, I further agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for the charges in a timely manner, or the physician or I fail to provide within (30) days the information necessary to submit the claim for payment.

_____

PATIENT (OR PARENT/GUARDIAN) DATE

_____

REPRESENTATIVE (IF PATIENT IS UNABLE TO SIGN) RELATION TO PATIENT