Confidential Personal Record

AMERICAN ORTHOPEDICS

Patient:_____ Home:_____

Address:_____ Cell:_____

City:_____ State:_____ ZIP:_____

Email:_____ DOB:_____ SSN:_____

Sex: ☐ M ☐ F Ethnicity:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

***I wish to receive appointment reminders and other communication by:** (select one) ☐ Text ☐ Email ☐ Call

Emergency Contact:_____ Phone:_____

Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Son/Daughter ☐ Friend ☐ Other:_____

*Primary Care Physician:_____ Phone:_____

*Prescribing Physician:_____ Phone:_____

*Diabetic Physician (if applicable):_____ Phone:_____

*Primary Insurance:_____ Phone:_____

*Secondary Insurance (if applicable):_____ Phone:_____

Resident of Nursing Facility? ☐ No ☐ Yes:_____ Phone:_____

☐ Skilled ☐ Hospice ☐ Home health care

BWC or Work Injury? ☐ No ☐ Yes, Claim No.:_____ Injury Date:_____

If yes, Employer:_____ Phone:_____

Address:_____

Is Patient a Minor? ☐ No ☐ Yes, Parent/Guardian:_____ Phone:_____

Address (if different than above):_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify American Orthopedics, Inc. of any changes in my insurance status or the above information. I understand, in case of default, I will be responsible for all fees associated with the collection of this account.

I understand that American Orthopedics, Inc. will fill the prescription from my physician as written. Other than slight modifications for comfort, they will not alter the basic prescription without direct orders from the physician. The professional staff at American Orthopedics, Inc. is comprised of licensed Orthotists and Prosthetists. As such, they provide, but do not prescribe, orthotic and prosthetic care.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date

Patient Medical History

Patient:_____

☐ There have been NO CHANGES to my Medical History SINCE MY LAST VISIT. (Sign and date below.)

Medical Complications (check all that apply):

☐ Arthritis ☐ Diabetes ☐ Edema ☐ Heart Disease

☐ Mental Disease ☐ Obesity ☐ Ulcers, callusing ☐ Serious visual impairment

☐ Other:_____

Have you had any previous surgeries related to your present condition(s)? ☐ No ☐ Yes, _____

_____

_____

_____

Are you currently wearing an orthosis? ☐ No ☐ Yes, _____

_____

Site of Amputation (if applicable):

☐ Above left knee ☐ Above right knee ☐ Below left knee ☐ Below right knee

☐ Other:_____

Surgeon:_____

Facility:_____

Date of Amputation:_____

Date previous prosthesis provided:_____ Company provided prosthesis:_____

I certify this information is true and correct to the best of my knowledge. I will notify American Orthopedics, Inc. of any changes to the above information.

_____ _____

Patient Signature (or Parent/Legal Guardian if a minor) Date