Privacy restrictions or other patient requests:

Impacting Lives Through Quality Patient Care

Demographic Sheet

PATIENT INFORMATION

LAST NAME: ______ FIRST NAME: ______ M: ______

SEX: ______ DATE OF BIRTH: ______ SSN#: ______

ADDRESS: ______ APT: ______ CITY: ______ STATE: ______ ZIP: ______

EMAIL: ______ MARITAL STATUS: (Circle one) Single Married Widowed Divorced

HOME PHONE: ______ CELL PHONE: ______ WORK PHONE: ______

*****Please circle the telephone number where we can best reach you or leave a message*****

HOW DID YOU HEAR ABOUT US?: ______ HEIGHT: ______ WEIGHT: ______

(Circle one) DIABETIC: Y N AMPUTEE: Y N LEVEL OF AMPUTATION: AK BK AE BE LEFT RIGHT BILATERAL

CONTAGIOUS DISEASES OR ILLNESSES? ______ DIALYSIS? M T W TH F

IS THIS RELATED TO AN INJURY? Y N WORK COMP INJURY? Y N AUTO ACCIDENT? Y N DATE OF INJURY: ______

SPOUSE/RESPONSIBLE PARTY – INFORMATION

LAST NAME: ______ FIRST NAME: ______ M: ______

RELATIONSHIP: ______

EMERGENCY CONTACT: ______ MAIN PHONE: ______

PRIMARY INSURANCE: ______ SECONDARY INSURANCE: ______

INSURANCE ID: ______ INSURANCE ID: ______

ASSIGNMENT AND RELEASE: I hereby certify that the above information is true and correct to the best of my knowledge. I hereby assign my insurance benefits to be paid directly to Horizon Prosthetics LLC. I am financially responsible for **ALL NON-COVERED** services. I also authorize that physician to release any information required to process my claim to insurance company.

X ______

(Signature of patient or parent/guardian if minor) (Date)

I give permission for my medical information or test results to be released to the following people:

1. ______ Relationship: ______