Patient Intake Form

(**please complete all questions to its entirely**)

Patient Information

Name _____ Soc. Sec #_____
Last Name First Name Middle Initial

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work/Mobile _____

Sex M ☐ F ☐ Age _____ DOB _____ Marital Status S ☐ M ☐ D ☐ W ☐

Employed Y ☐ N ☐ Occupation _____ Email _____

Referring Physician _____ Phone _____

In case of emergency, who should be notified? _____ Phone _____
(relationship)

Primary Insurance

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____ Subscriber Soc. Sec #_____

Address (if different from patient's) _____

Insurance Company _____ ID # _____

Secondary Insurance

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____ Subscriber Soc. Sec # _____

Address (if different from patient's) _____

Insurance Company _____ ID # _____

Disclosure of Information

I, the undersigned, certify that I understand that my medical records and billing information are made and retained by Prosthetic & Orthotic Designs, LLC and are accessible to POD personnel who may use and disclose medical information for POD's operations and functions and to any other health care personnel involved in my continuum of care for this admission.

Responsible Party Signature _____ Date _____