SYRACUSE PROSTHETIC ORTHOTIC CENTER

PATIENT INFORMATION

How did you hear about us? ☐Newspaper Ad ☐Social Media ☐Patient ☐Friend ☐Other_____

Patient Name _____ Date_____

DOB _____SSN (Last 4 Digits) _____ Ht_____ Wt_____ Shoe Size_____

Address _____City_____ State_____ Zip Code_____

Home Phone_____ Work_____ Cell_____

Please Circle Preferred Phone Email _____

Emergency Contact_____Phone_____Relationship_____

Referring Physician _____Primary Care Physician _____

Date of Surgery _____ Surgeon_____

Are you currently receiving Physical Therapy? YES / NO

If yes, Physical Therapist Name _____

Address/Phone:_____/_____

IF PATIENT IS A MINOR: Parent/Guardian _____DOB_____

Phone _____Address, if different from patient_____

INSURANCE INFORMATION

Medicare HIC# _____ Medicaid ID# _____

Private Insurance Carrier _____ID# _____

Address/City/State/Zip _____Phone_____

Insurance Subscriber Name _____DOB._____

Worker's Compensation or No Fault Claim:

Ins. Carrier Address_____City_____State_____Zip Code_____

Date of Injury/Accident_____File/Claim#_____

Employer_____ WCB Case # _____

ORTHOTIC MEDICARE PATIENTS

In the past five years have you received the same or similar type of brace from another facility, doctor, or physical therapist?

☐Yes ☐No If Yes, Item received_____ Issuer_____ when_____

Do you currently live (permanently or temporarily) in a skilled nursing facility, intermediate care facility, or another facility? ☐Yes ☐No If Yes, Facility _____ Phone _____