Welcome to: Spears Prosthetics & Orthotics

Patient Information Sheet

Patient Information (All Information is confidential and will not be given out)

Name:_____ Sex:_____ D.O.B._____

Address:_____ City:_____ St:_____ Zip:_____

Home Phone ( )_____ Cell Phone: ( )_____

Emergency Contact:_____ Phone #_____ Relationship_____

Social Security #_____ HT:_____ WT:_____

What is your shoe size?_____

Marital Status: Single_____Married_____ Divorced_____ Widow_____

Email Address_____

Have you ever had any type of brace before? Yes_____ No_____ If Yes please tell us what._____

WORK INFORMATION

Employer Name_____

Employer Address:_____

Work Number:_____

Work Email Address_____

INSURNACE INFORMATION

Primary Insurance_____

Policy/Id #_____

Policy Holders Name_____ D.O.B_____

Secondary Insurance_____

Policy/Id #:_____

Policy Holders Name_____ D.O.B_____

Workers Compensation:

Is your condition the result of an injury? Yes____No_____ Date of Injury:_____

Was your injury work related? Yes_____ No_____ Claim #:_____

Name of Adjuster:_____Phone #_____

Physician Information

Name of the Physician that referred you Dr._____ Phone #:_____

Are you a diabetic? Yes or No_____ If so, Who is your diabetic doctor that gives you your insulin or pill? Dr._____Phone #_____

HEALTH INFORMATION

Please check by indicating any of the following you have experienced:

_____Heart Surgery/attack/disease ___Stroke/ Paralysis ____Bleeding disorder ____ Kidney Disease
_____Insulin dependent diabetic ____Balance problems _____Cancer ____Liver Disease
_____Non-Insulin dependent diabetic ___Osteomyelitis _____Arthritis _____Depression ___Anxiety
_____Lung/Respiratory Problems _____Pain _____HIV/AIDS ___Staph or other infections ___PVD
_____Poor Circulation____Sores/Open Wounds_____Hepatitis A,B,C _____Vision Problems
_____High or Low Blood Pressure ____Blood Clots_____Seizure Disorder____Hearing Impaired

If you checked any of these conditions above or are experiencing others, Please indicate the specific nature below.

_____

_____

Please list any allergies that you have(especially to latex, creams, dyes, or other materials):_____

_____

Please list any surgeries below:

_____ **Date**_____ **Surgeon**_____
_____**Date**_____**Surgeon**_____

The undersigned certifies that the above information is true, accurate and complete:

Print Name of Patient_____

Signature of Patient/Guarantor:_____ **Date**_____