SOUTHEASTERN
ORTHOTICS AND PROSTHETICS

PATIENT INFORMATION

Patient Name:

_____

(First) (MI) (Last)

Date of Birth: _____ SS #: _____ - _____ - _____ Gender M_____ F _____

Vocational Category: Unemployed _____ Employed _____ Student _____ On Disability _____ Retired_____

Street Address: _____City, State, Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Reminder Method: Best way RHS can reach you for confirming appointment? Home ___ Cell ____ Work ___ Email ____

E-mail Address: _____

Weight _____ Height _____ Marital Status S _____ M _____ D _____ W_____

DATE OF AMPUTATION: _____

ARE YOU A VETERAN: YES _____ NO _____ Did the VA refer you? ___YES ___NO

EMERGENCY CONTACT

Name of Contact _____Phone: _____ Relationship to Patient: _____

PRIMARY CARE PHYSICIAN _____ Phone: _____

REFERRING PHYSICIAN _____ Phone: _____

MEDICAL INFORMATION *(Please Complete this Section Fully)*

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Were you injured in an automobile accident?	YES ☐	NO ☐
Is your condition due to a work-related injury?	YES ☐	NO ☐
Have you had a brace or artificial limb in the past 5 years?	YES ☐	NO ☐
Do you have a latex / neoprene allergy?	YES ☐	NO ☐
Are you Diabetic?	YES ☒	NO ☐

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If Yes, please list diabetic treating physician: _____Phone #: _____

PROSTHETIC PATIENTS: Left ☐ Right ☐ Below Knee ☐ Above Knee ☐ Upper Extremity ☐
Date of Amputation: _____
MEDICAL HISTORY Height: _____ft. _____in. Weight: _____lbs.
Are you currently residing in a nursing home/or are you going to be residing in a nursing facility within the next 30 days: Yes No If yes, Facility Name: _____
Activity level: ____Low ____Medium ____High ____Highly active
How would you describe your general health? ____Poor ____Fair ____Good ____Excellent

Do you have any contact precautions or communicable disease our staff should be aware of: Yes No
(For example: MRSA, Staph, Strep A, etc.)? If yes, explain:

_____

Attending Therapy? ____Physical ____Occupational ____Both
Therapist: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Ins. Co.: _____

Subscriber or ID# _____ Group Number _____

Name of INSURED _____ Employer of INSURED _____

Relationship to Patient: _____ DOB _____ Soc. Sec. # ____ - _____ - ____

SECONDARY INSURANCE *Name of Ins. Co.:* _____

Subscriber or ID# _____ Group Number _____

Name of INSURED _____ Employer of INSURED _____

Relationship to Patient: _____ DOB _____ Soc. Sec. # ____ - _____ - ____

WORKER'S COMP. INSURANCE CARRIER _____

Case Manager _____ Claim # _____

Phone # of Case Manager: _____ Injury Date: _____

Employer Name _____

Address _____ Phone #_____

QUESTIONS FOR THE PATIENT

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MEDICARE PATIENTS ONLY

Are you enrolled in a Medicare HMO/Managed Care Program? Yes _____ No _____

Has the patient been enrolled in a Medicare HMO/Managed Care program and now planning on returning to the Traditional Medicare Part B? Yes _____ No _____

Have you ever received the same or similar device before? Yes _____ No _____

If YES, WHEN and WHERE was it dispensed from? Company name _____

Approximate date _____

Was item returned? Yes ____ No ____ If YES, what was the return date? _____

Is item being replaced? Yes _____ No _____

PATIENT ASSIGNMENT OF BENEFITS/MEDICAL INFO. RELEASE CONSENT

My signature below hereby requests that payment of all authorized Medical benefits be made to Restorative Health Services, Inc., on my behalf for any and all services furnished to me by Restorative Health Services, Inc. I authorize any holder of medical information about me to be released to Restorative Health Services, Inc., and its agents any information needed to determine these benefits or for the requirements of Restorative Health Services, Inc., the benefits payable for related products and services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance or not. Any legal fees or collection fees incurred to collect this account will be added to the outstanding balance and become part of the new balance owed to Restorative Health Services, Inc..

I understand that an authorization for services and products by my insurance carrier is not a guarantee of benefits or payment by the insurance carrier. Final eligibility will be determined at the time the claim is received by my insurance carrier. Benefits are subject to all contract terms, conditions, exclusions and to a patient's eligibility at the time products and services are rendered which is known as the "Date of Service". Any benefit or eligibility information received prior to claim receipt and adjudication by the carrier is solely an estimate and not definitive.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Representative Print Name	Representative Signature	Date

PLEASE CHECK ONE OF THE FOLLOWING PERMISSION STATEMENTS:

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_____ Permission IS given for RHS to contact me by mail, phone, or voice mail message, to schedule, re-schedule, or remind me of appointments or to inform me of any insurance carrier information pertinent to my service or product being rendered.

**Please give us the name of the person(s) to whom we can share Restorative Health Services, Inc. information with if you are unable to answer the call:_____

_____ Permission IS NOT given to Restorative Health Services, Inc. to contact me by mail,

phone, or voice mail, to schedule, re-schedule, or remind me of appointments or inform me of an

insurance authorization that may be expiring.

I was offered Restorative Health Services, Inc. Privacy Practices.

I was informed of and offered a copy of the Medicare Supplier Standards.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Representative Print Name	Representative Signature	Date