NEW HOPE PROSTHETIC & ORTHOTICS SERVICES, INC

PATIENT INFORMATION:

Today's Date: _____ Patient Name: _____

If patient is a minor, please list the name(s) of parent(s) or legal guardian(s):

_____ _____

Name & Relationship Name & Relationship

Date of Birth: _____ Gender (circle): M F Soc Sec#: _____

Vocation (circle): Employed Student Homemaker Unemployed Disability Leave of Absence Retired

Patient's Employer: _____ Work Phone: (___)_____

Marital Status (circle): Single Married Divorced Widowed Spouse Name: _____

Home #: (___)_____ Cell #: (___)_____ Email: _____

Address: _____ City: _____ State: ___ Zip: _____

Mailing Address (If different): _____

EMERGENCY INFORMATION:

Contact Name: _____ Phone #: _____

Relationship to patient: _____

INSURANCE INFORMATION: Self Pay ___

Primary Insurance: _____

Insurance ID #: _____ Group #: _____

Name of Insured IF other than patient: _____ Date of Birth: _____

Secondary Insurance: _____

Insurance ID #: _____ Group #: _____

Name of Insured IF other than patient: _____ Date of Birth: _____

If Workers Comp:

Insurance company name: _____

Claim #: _____ Case Manager Name & #: _____

PHYSICIAN INFORMATION:

Referring Physician: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: (___)_____ Fax: (___)_____

Primary Care Physician: _____

Address: _____ City: _____ State: ___ Zip: _____

Phone: (___)_____ Fax: (___)_____

Physical Therapist (if applicable): _____ Phone: (___)_____

MEDICAL HISTORY:

General Health (check): Poor_ Fair_ Good_ Excellent_ Height: ____ Weight: ____ Shoe Size: _____

Patient currently has or had (check all that apply):

	Heart Problems		Hepatitis		MRSA
	Hypertension		Vascular Disease		Pacemaker/Defibrillator
	Osteoporosis		Rheumatoid Arthritis		HIV Positive
	Stroke		Osteoarthritis		Seizure Disorder
	Diabetes		Respiratory Disease		Hearing Loss
	Kidney Disease		Vision Problems		Currently Pregnant

Other condition(s) not listed above: _____

If Diabetic, list physician treating you: _____

List any known allergies (including contact materials): _____

Date & Reason for amputation: _____

Level of amputation: Left __ Right __ Above knee __ Below knee __ Above Elbow __ Below Elbow __
Level of amputation on foot or hand: _____

Dates (and reasons) of any revision surgery: _____
_____

Is this your first prosthesis? Yes __ No __ If no, please answer the following questions:

When were you last fit? _____ Name of facility: _____

What issues are you having with your current prosthesis, if any? _____
_____

Describe any limitations in walking prior to your amputation, if any? _____
_____

List daily activities you wish to resume and long-term goals in using a prosthesis: _____
_____

Do you authorize your practitioner to take photo's or video of you for your medical record? Yes __ No __

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INSURANCE AUTHORIZATION AND MEDICAL RELEASE

I certify that the information provided is true, accurate and complete. I hereby authorize my insurance company(s), Medicaid and/or Medicare to pay directly to New Hope Prosthetic & Orthotic Svcs, Inc. all benefits due for services furnished by the aforementioned. Additionally, this authorization includes any secondary insurance coverage I currently have. I understand that for all charges not covered by insurance or any other source, including collection fees, I am financially responsible to New Hope Prosthetic & Orthotic Svcs, Inc. I authorize New Hope Prosthetic & Orthotic Svcs, Inc to obtain or release medical records to whomever they deem appropriate to facilitate my care. Patient confidentiality will be maintained. A photocopy of this agreement is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing.

HIPAA-Notice of Privacy Practices - This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *For your personal copy to review, please ask for a printout.*

MEDICARE DMEPOS SUPPLIER STANDARDS - Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424. *For your personal copy to review, please ask for a printout.*

_____ _____ _____

Signature of Patient or Personal Representative	Date	Description of Personal Representative (if needed)