Integrity Prosthetics
Patient Intake Form

Section 1 - Patient Information

Patient Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Age _____ Sex: Male / Female SSN _____ Email _____

Vocation ___Employed ___ Student ___ Homemaker ___ Unemployed ___ On Disability ___ Retired ___ Child

Drivers License # _____ Marital Status ___ Single ___Married ___Divorced ___Widowed

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address _____ City _____ ST ____ Zip _____

Work Address _____ City _____ ST ____ Zip _____

Mailing Address (if different from Home Address) _____ City _____ ST ____ Zip____

Section 2 - Contact Information

Spouses Name _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

May we speak to your spouse or emergency contact regarding your care? ___ Yes ___ No

Section 3 - Insurance/Payment Info

Are you a Veteran? ____ Yes ____ No If yes, is the VA responsible for your coverage? ____ Yes ____ No

Do you have Insurance? ___ Yes ___ No If No, person responsible for Account _____

Primary Insurance _____ ID # _____ Grp # _____ Plan _____

Relationship of Patient to Insurance Subscriber ___ Self ___ Spouse ___ Child

If Spouse or Child, Please Provide Primary Subscriber Info:

First Name _____ Last Name _____

Date of Birth _____ SSN _____

Address _____ City _____ ST ____ Zip _____

Secondary Insurance _____ ID # _____ Grp _____ Plan _____

If Work Related, Workman Comp Carrier _____

Adjuster's Name _____ Phone _____

Over →

Section 4 - Medical Information

Type of Amputation ____ Right Side ____ Left Side ____ Bilateral

___ Above Knee ___ Below Knee ___ Above Elbow ___ Below Elbow

Date of Amputation _____ Is your condition a result of __ Accident from Employment

___ Auto Accident ___ Other Accident _____ ___ Congenital ___Other _____

Currently wearing a prosthesis? Yes / No If yes, how long have you been wearing your current limb? _____

When was your most recent limb made? _____ Where was it made?_____

Height _____ Weight _____ Do you lift or carry over 30 pounds at work or home? Yes / No

Please check any of the following conditions that apply ___ Heart Problems ___Hypertension ___ Vascular Disease

___ Stroke ___ Diabetes ___ Kidney Disease ___ Hepatitis A or B ___ HIV Positive ___Rheumatoid Arthritis

___ Osteoarthritis ___ Pulmonary Disease (TB) ___ Vision Problems ___ Parkinson Disease ___Alzheimer Disease

___ Psychiatric Problems ___ Alcoholism ___ Allergies to contact materials/Latex Allergy ___ Obesity

List any other conditions that you feel might affect your treatment _____

_____

Currently taking medications _____

_____

Do you have a physician's prescription for a prosthesis? ___ Yes ___ No

Primary Care Physician _____ Tel # _____

Referring Physician _____ Tel # _____

Are you diabetic? Y / N Physician Managing Diabetes _____ Tel # _____

Section 5 - Comments & Referral Source

What would you like to do with your prosthesis? _____

_____

Do you have any questions, special needs or information you would like from us? _____

_____

How did you hear about Integrity Prosthetics?

___ Physician Referral (name)_____ ___ Cardinal Hill Amputee Clinic

—-- Physical Therapist (name) _____ ___ Friend (name) _____

___ Integrity Prosthetics Employee (name) _____ ___ **Web Site** ___**Drove by (Saw Sign)**

___ TV Ad (Channel) _____ **____ Facebook** **___Instagram** **____ YouTube** **____ Twitter**

Other _____