Today's Date: _____/_____/2012

Referring Physician: _____

Diagnosis: _____ ☐ right ☐ left

Date of Injury: _____ Cause: _____

_____

SHAW'S PROSTHETICS PLUS, INC.

PATIENT REGISTRATION FORM

PATIENT INFO

Patient Name: _____
(first) (middle/maiden) (last)

Address: _____
(street) (city) (state) (zip code)

Home phone: _____ Cell phone: _____

Soc. Sec. # _____-_____-_____ Age: _____ Birthdate: _____/_____/_____

☐ Male ☐ Female HEIGHT_____ WEIGHT_____ Shoe size: _____ (applies to lower extremity patients)

Your Employer: _____ Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

EMPLOYER INFO

If Married, Spouse's Name _____

Spouse's Employer: _____ Phone: _____

If Patient is a Minor – Father's name _____ Mother's Name _____

Emerg. Contact: _____ Rel. _____ Phone: _____

Is this visit pertaining to a Workers' Comp accident? ☐ No ☐ Yes If yes Date of accident ____/____/_____

Description: _____

Employer: _____

BILLING INFO

Send account information to Or leave message with: ☐ home address ☐ work/office ☐ E-mail @ address _____

☐ answering machine ☐ other specify) _____

Permission to discuss my account with: (privacy regulation) ☐ myself ☐ spouse ☐ parent if child or dependent

☐ insurance and/or Workers' Comp. Carrier

☐ personal representative(s) (specify) _____

_____

My signature indicates the above information is true to the best of my knowledge. I authorize the release of medical or other information necessary to Shaw's Prosthetics Plus, Inc., for orthotic and/or prosthetic treatment. I also authorize release of information necessary for insurance claim filing purposes.

I understand not all items may be covered by my insurance policy. Coverage verification with my insurance carrier does not guarantee a payment from them. It is my responsibility to provide Shaw's Prosthetics Plus, Inc with up-to-date insurance information. I also understand I am ultimately responsible for any allowed amount not paid for or covered by insurance.

X _____ Date: _____/_____/2012

2012

Dominant side: ☐ right handed ☐ left handed

Sensation: right side: ☐ good ☐ poor

Left side: ☐ good ☐ poor

Are you currently taking physical therapy? ☐ Yes ☐ No

If Yes, where: _____

Name of P/T: _____

Have you received the same or similar item as prescribed by your physician today in the past 5 years?

☐ Yes ☐ No

If yes, when? _____

From whom? _____

ENVIRONMENTAL STATUS (check all that apply)

☐ Use steps/stairs on a daily basis

☐ Access to elevator

☐ Walk / run on uneven terrain (hilly or rocky area)

☐ Need assistance walking or other daily activities

☐ Use following walking aids:

☐ wheelchair ☐ walker ☐ cane ☐ crutches

ALLERGIES (check all that apply)

☐ Rubber

☐ Latex

☐ Metal (type) _____

☐ Adhesives _____

☐ Material (wool, cotton, etc.) _____

_____

REVIEW OF SYSTEMS (check all that apply)

☐ **Diabetes**

☐ Insulin dependent

☐ Oral medication controlled

☐ Diet controlled

☐ Name of diabetic physician:

_____

☐ **Heart disease** _____

☐ **High Blood Pressure**

☐ **Arthritis**

☐ Osteoarthritis ☐ Rheumatoid

☐ **Osteoporosis**

☐ Kyphosis (severely rolled shoulders)

☐ Scoliosis (curvature of spine)

☐ Chronic Back Pain

☐ Chronic leg pain ☐ right. leg ☐ left leg

☐ **Amputation(s)**

☐ Toes

How many? _____ ☐ right foot ☐ left foot

☐ Partial foot ☐ right foot ☐ left foot

☐ Complete foot ☐ right foot ☐ left foot

☐ Below-the-knee ☐ right leg ☐ left leg

☐ Above-the-knee ☐ right leg ☐ left leg

☐ Fingers

How many? _____ ☐ right hand ☐ left hand

☐ Partial hand ☐ right hand ☐ left hand

☐ Complete hand ☐ right hand ☐ left hand

☐ Below-the-elbow ☐ right arm ☐ left arm

☐ Above-the-elbow ☐ right arm ☐ left arm

Excessive Weight fluctuation

☐ loss _____lbs. ☐ Gained _____lbs.

☐ **Senile dementia**

☐ **Alzheimer's disease**

☐ **Stroke** when: _____

☐ **TIA (mini-stroke)** when: _____

☐ **Parkinson's disease**

☐ **Cerebral Palsy**

☐ **Spina Bifida**

☐ **Visual impairment**

☐ Contacts? ☐ Eyeglasses?

☐ Blindness _____

☐ **Hearing impairment** ☐ right. ear ☐ left ear

☐ **Physical impairment** _____

☐ **HIV exposure**

☐ **Hepatitis B** ☐ **Hepatitis C**

☐ **MRSA**

☐ **Are you currently pregnant?** ☐ Yes ☐ No

If YES, how many months? _____

MAJOR ILLNESS / SURGERY HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications: _____

_____

_____

_____