Spartan
Orthotics and Prosthetics

Today's date: ___ /___ /_____
Patient name:_____ Date of birth: ____/___/_____
Gender: M / F Patient social security #: _____ Education:_____
Ethnicity: _____
Marital status: ☐ Single ☐ Married ☐ Other

Address: _____ City: _____ State: _____Zip: _____
Home Phone: (_____)_____ Work phone: (_____)_____ Mobile number: (____)_____
Email: _____ For internal use only; will not be shared.

Parent/Guardian 1 (if patient is minor): _____ Relationship:_____
Parent/ Guardian 2 (if patient is minor):_____ Relationship:_____

Contact Information

Emergency contact other than Parent/Guardian: _____
Relationship: _____ Phone: (____)_____
I _____ give permission for the listed Emergency contact to sign for patient or guardian on
Patient/Parent/Guardian
my behalf if I am unable. _____
Signature

Physician Information

Referring Physician: _____ Primary Physician: _____

Please answer the following:	No	Yes	
Was this due to a work related injury?	☐	☐	When? ___/___/_____
Falls within the last six months?	☐	☐	When? ___/___/_____
Was this due to an auto injury?	☐	☐	When? ___/___/_____ State:_____
Was this due to other accident?	☐	☐	When? ___/___/_____ What: _____
Are you receiving home health care services?	☐	☐	When? ___/___/_____
Condition since birth?	☐	☐	

Are you currently or have you recently been in hospital, nursing home or rehabilitation facility?
☐ No ☐ Yes Name: _____

Have you received a same or similar item within the past five years? ☐ No ☐ Yes When? ___/___/_____

General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Activity Level: ☐ Not Active ☐ Less Active ☐ Active ☐ Very Active

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Insurance and Billing Information

Primary Insurance: _____ Subscriber: _____
Date of birth: ___/___/_____ Policy ID #: _____ Group #: _____
Relationship to subscriber: ☐ Self ☐ Parent/Guardian ☐ Child ☐ Spouse ☐ Other
Employer:_____

Secondary Insurance: _____ Subscriber: _____
Date of birth: ___/___/_____ Policy ID #: _____ Group #: _____
Relationship to subscriber: ☐ Self ☐ Parent/Guardian ☐ Child ☐ Spouse ☐ Other
Employer:_____

Tertiary Insurance: _____ Subscriber: _____
Date of birth: ___/___/_____ Policy ID #: _____ Group #: _____
Relationship to subscriber: ☐ Self ☐ Parent/Guardian ☐ Child ☐ Spouse ☐ Other

Allergies ☐ No ☐ Yes Please list:

Currently taking medications related to your visit?
☐ No ☐ Yes Please list:

Have had major surgeries? ☐ No ☐ Yes Please list:

All provided information is HIPPA protected.