Pongratz Orthotics & Prosthetics, Inc.

Patient Name: _____ Birthdate: _____

Street Address: _____ Sex: Male Female

City, State, Zip: _____ Height: _____

Email Address: _____ Weight: _____

Cell Phone: _____ Employment Status: _____

Home Phone: _____ Marrital Status: _____

Work Phone: _____ Language: _____

Social Security #: _____ Are you Diabetic? Yes No

Are you a resident in a Skilled Nursing Facility, Assisted Living, Specialty Hospital, or Rehab? Yes No

Have you ever received a silmilar device? Yes No If yes, How Long Ago? _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Diabetic Doctor: _____ Phone: _____

Physical Therapist: _____ Phone: _____

EMERGENCY CONTACTS: Spouse, Parent, Guardian, etc. (If patient is a minor this section must be completed fully)

Name: _____	Name: _____
Birthday: _____	Birthday: _____
SS#: _____	SS#: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____
Relation to Patient: _____	Relation to Patient: _____

Primary Insurance: _____	Secondary: _____
Policy/ID #: _____	Policy/ID#: _____
Group #: _____	Group #: _____
Policy Holder: _____	Policy Holder: _____
Policy Holder DOB: _____	Policy Holder DOB: _____
Relationship: _____	Relationship: _____

Workmans Comp Case: Yes No Date of Injury: _____

Insurance Carrier: _____ Claim#: _____

Adjuster: _____ Employer at DOI: _____

Adjuster's Phone: _____ Employer's Phone: _____

I hereby authorize the release of information regarding my/the patient's condition/treatment, as necessary to process this and/or related claims. I also certify that all information contained herin is accurate and correct.

_____

Signature: Patient or Responsible Party (circle one) Date: