



PATIENT INFORMATION

PATIENT INFORMATION	<p>PATIENT NAME: _____ DOB: _____</p> <p>ADDRESS: _____</p> <p>CITY: _____ STATE: _____ ZIP: _____</p> <p>CELL PHONE: _____ HOME PHONE: _____</p> <p>EMERGENCY CONTACT NAME/PHONE: _____</p> <p>EMAIL: _____</p> <p>HEIGHT: _____ WEIGHT: _____ DIABETIC: YES or NO</p>
PRIMARY INSURANCE	<p>PRIMARY INSURANCE: _____</p> <p>POLICY #: _____ GROUP #: _____</p> <p>PHONE: _____</p>
SECONDARY INSURANCE	<p>SECONDARY INSURANCE: _____</p> <p>POLICY #: _____ GROUP #: _____</p> <p>PHONE: _____</p>
PHYSICIAN INFORMATION	<p>REFERRING PHYSICIAN: _____ PHONE: _____</p> <p>PRIMARY PHYSICIAN: _____ PHONE: _____</p> <p>DIABETIC PHYSICIAN: _____ PHONE: _____</p>
MEDICAL HISTORY	<p style="text-align: center;">PLEASE CHECK ALL THAT APPLY</p> <p><input type="checkbox"/> Is your condition a result of an accident from employment?</p> <p><input type="checkbox"/> Is your condition a result of an auto accident?</p> <p><input type="checkbox"/> Is your condition a result of any other type of accident? If so, explain: _____</p> <p>_____</p> <p>General Health: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent</p> <p>Any health issues we should know about? _____</p> <p>Reason for visit today? _____</p> <p>_____</p> <p>Have you ever had the same or similar device? _____</p> <p>If so, when? _____ From what company? _____</p> <p>Activities/Hobbies: _____</p> <p>_____</p>



MEDICAL HISTORY

Visit Date: _____

Patient Name _____ Patient DOB: _____

General Health Excellent Good Fair

Tobacco Use Yes No

Falls in the last 6 months? Yes No

Hospital, ER, or Urgent Care Visits in the last 6 months? Yes No

Accident from Employment? Yes No Date _____ State _____

Description of Accident _____

Auto Accident? Yes No Date _____ State _____

Other Accident? _____

Condition Since Birth? Yes No

Have you received a same or similar device in the past 5 years? Yes No Date _____

Details, from what facility and when? _____

Do you have an amputation? Yes No

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

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Alzheimer Disease
<input type="checkbox"/> Hypertension	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Stroke	<input type="checkbox"/> Obesity	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pulmonary Disease (TB)	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Hepatitis A or B	<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> MRSA

