KOOTENAI
PROSTHETICS
& ORTHOTICS

Patient Information:

Last Name: First Name: Middle

Name:D.O.B: Male Female SSN:

Primary Phone: Alternative Phone:

Home Address:

Mailing Address:

Employment Status: Marital Status:

Emergency Contact: Phone:

Email Address: Electronic Statements? YES NO

Responsible Party: Phone:

Mailing Address:

Insurance:

Primary Insurance: Policy Number:

Name of Insured: Relationship: DOB:

Secondary Insurance: Policy Number:

Name of Insured: Relationship: DOB:

Is This Work or Auto Related? Yes No If Yes: Claim Number:

Adjuster's Name & Number:

Employer (At Time of Incident): Date of Incident:

Have you received an Orthosis (Brace) or Prosthesis (Artificial Limb) in the last 5 years? Yes

NoIf Yes: Date Received: Description:

Received From:

How did you hear about us?

Primary Care Doctor: Referring Doctor:

Continued other side...

Are you Diabetic? Yes No If Yes, Doctor managing your diabetes:

Other Health Concerns:

Allergies:

Medications you are taking:

Reason for visit today:

Do you reside in a skilled nursing facility (nursing home)? Yes

NoDo you reside in Hospice Care?

Yes No

Patient Acknowledgement:

Balance is due at the time of service. This office does not carry balance or finance monthly payments. Whether you insurance pays or not, the balance on the account is your responsibility. As a courtesy, we bill most insurance companies, and provide them with the necessary documentation required for benefit disbursement. You, the patient, are requesting that the insurance benefits, if any, be paid directly to us, the provider. You are authorizing the release of any information only necessary to provide services, or process claims. You understand that you are personally liable for the entire amount of your claim and that insurance benefits, including Medicare, may be limited or non-existent. You agree to notify Kootenai Prosthetics and Orthotics, Inc. of any change(s) in insurance coverage or status. You agree to the payment/financial policy of Kootenai Prosthetics and Orthotics that has been provided to you.

Signature of Patient/ Responsible Party Date Signed

Printed Name of Patient/Responsible Party

Website and Social Media Release

I, the undersigned, do hereby grant permission to Kootenai Prosthetics and Orthotics to use and distribute my first name, story and photos in web, social media, and print format. I hereby release Kootenai Prosthetics and Orthoticsand all representatives of from all claims and demands arising out of or in connection with any use of said photos or information. This authorization is valid from this signed date and will expire only upon revocation of this authorization by providing written notice to Kootenai Prosthetics and Orthotics. I understand that I am entitled to acopy of this authorization. I further understand that this authorization is fully voluntary and that my refusal to sign will not affect my eligibility for benefits or enrollment or payment for coverage of services.

Signature Date Signed

Signature of Parent or Guardian (If Patient is a Minor)