Kentucky Prosthetics and Orthotics, Inc
Information Form

Patient Information

Last Name: _____ First: _____ MI:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work _____ Cell:_____

Email Address_____

Date of Birth: (mm/dd/yyyy):_____ Sex □M □ F

Martial Status: □S □M□ D □W Spouse Name _____

Social Security Number: _____

Primary Care Physician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

Diagnosis: _____ Are you Diabetic?_____

Height_____ Weight:_____ Shoe Size:_____

Emergency Contact (person who does not live with you) _____Phone Number_____

Is this related to a car accident: yes no

Primary Insurance (copy of card is required)

Insurance Company: _____ Policy Holder:_____

Policy Holders date of birth _____ Social Security Number_____
(if different than patient)

Secondary Insurance (copy of card is required)

Insurance Company: _____ Policy Holder:_____

Policy Holders date of birth _____ Social Security Number_____
(if different than patient)

Workers Compensation

Name of Compensation Carrier:_____ Phone:_____

Claim# _____ Date of Injury_____

Employer:_____ Contact: _____

I, hereby authorize the release of any and all medical or other information necessary to process this claim. I also authorize payment directly to Kentucky Prosthetics and Orthotics, Inc. I understand that I am financially responsible to Kentucky Prosthetics and Orthotics for any and all charges not covered by insurance. I verify that to my knowledge all information is correct and that I will contact Kentucky Prosthetics and Orthotics if any information changes.

Signature: _____ Date: _____