Patient Information:

Last name: ______________________________ First name: _________________________________

Middle name: __________________________ Preferred name: _____________________________

Date Of Birth: ___ /____ /____ (MM/DD/YYYY) Gender: ☐ Male ☐ Female SSN: _____ - ___ - _____

E-mail address: ____

Race: ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian
☐ White ☐ Black/African American ☐ Other ☐ Hispanic/Latino ☐ Prefer not to answer

Armed Forces: ☐ Active Service Member ☐ Reserve Service Member ☐ Veteran
☐ Not a member ☐ Prefer not to answer

Education: ☐ Some High School ☐ High School/GED ☐ Some College or Tech Degree
☐ College Degree ☐ Graduate Degree ☐ Prefer not to answer

Vocational category: (Please check one)

☐ Employed Full-time ☐ Pediatric Patient ☐ Retired ☐ On Disability
☐ Employed Part-time ☐ Student Full-time ☐ Student Part-time
☐ Unspecified ☐ On Leave of Absence ☐ Unemployed

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Responsible party information (if patient is under 18 years of age)

Name: _______________ Relationship to patient: ____________Phone number: __________________

Mailing Address:

Street: _____________________________City: ___________________ State: _____ Zip: __________

Language: ___________ Home Phone#: __________________ Cell/Mobile#: ___________________

Emergency Contact: (Not living in the household)

Name:___________________________ Phone number:_______________________

Primary Care Physician: _____________________ Referring Physician: ________________________

Involvement of Others in my Care:

I, __________________________, authorize Total Care Orthotics and Prosthetics to discuss my/the patient's care and medical needs with the following persons:

Name (printed)	Relationship	Phone Number
_____________________	_____________________	_____________________
_____________________	_____________________	_____________________

Insurance Information:

Primary policy holders Name: _________________________________ Date of Birth: ________________
Insurance Co: ________________________ ID#:___________Group#: ____________ Plan#: ___________

Secondary policy holders Name: _______________________________ Date of Birth: _______________
Insurance Co: ________________________ ID#:___________Group#: ____________ Plan#: ___________

Tertiary policy holders Name: ________________________________ Date of Birth: _______________
Insurance Co: ________________________ ID#:___________Group#: ____________ Plan#: ___________

Worker's Comp Case? ☐ Yes ☐No Date of injury/accident: ____ / ____ / _____ (MM/DD/YYYY)
Adjuster's Name/Case Manager: ______________________ Contact Number:_______________________

Patient Signature: _________________ Date: ________________