TOTAL CARE
ORTHOTICS and PROSTHETICS

General Information:

Last name: _____ First name: _____

Middle name: _____ Nickname: _____

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

E-mail address: _____

Race: ☐ American Indian/Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Black or 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 ☐ Employed Part-time ☐ Student Full-time
☐ Student Part-time ☐ Unemployed ☐ On Disability
☐ Peds Patient ☐ Retired ☐ Unspecified ☐ On Leave of Absence

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

Address:

Street: _____ City: _____ State: _____ Zip: _____

Language: _____ Phone#: _____ Cell/Mobile#: _____

Patient Contacts (Emergency contact with different number)

Emergency Contact/relationship: _____ Phone#:_____

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Primary Physician: _____ Referring Physician: _____

Authorization To Release Information:

Purpose: This is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____	_____
Name (printed)	Relationship	Phone Number
_____	_____	_____
Name (printed)	Relationship	Phone Number

Insurance Info:

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