Orthotic & Prosthetic
SPECIALTIES INC.

PATIENT INFORMATION - Please Print and Complete All Fields	
Patient Name (First, MI, Last):	
Date of Birth:	**Social Security #:**
Email Address:	
Home Phone:	**Cell Phone:**
Do you consent to receiving future appointment reminders via text, automated message and/or Email to the home phone, cell phone, and/or Email address you provided? Y N	
Address:	**City/State/Zip:**
Is the Patient Currently in a Nursing Home: Y N **If Yes, Name of Nursing Home:**	
Height: **Weight:** lbs **Sex:** M F	
Emergency Contact:	**Phone:**

INSURANCE INFORMATION		
Primary Insurance:	**ID#:**	**Group #:**
Please answer below if the primary insurance subscriber is someone other than the patient:		
Subscriber Name: **Relationship to Patient:**	**Date of Birth:**	
Secondary Insurance (if applicable):	**ID#:**	**Group #:**
Please answer below if the secondary insurance subscriber is someone other than the patient:		
Subscriber Name: **Relationship to Patient:**	**Date of Birth:**	

PHYSICIAN INFORMATION	
Primary Physician: **Location:**	**Phone:**
Referring Physician: **Location:**	**Phone:**
Diabetic Physician (if applicable)**:** **Location:**	**Phone:**

PLEASE COMPLETE THIS SECTION IF THE PATIENT IS UNDER THE AGE OF 18	
Responsible Party/Guardian:	**Relation:**
Does the Responsible Party/Guardian Live at the Address Listed Above? Y N **If No, Address:**	**Phone:**