Strive ORTHOTICS & PROSTHETICS, LLC

Patient Information

Name:____ Nickname:______________
First Middle Last

Date of Birth:_____/_____/_______ Social Security Number:______-______-________

Gender: ☐ Male ☐ Female Email:_______________________________________

Marital Status:☐Single ☐ Married ☐ Divorced ☐ Widowed Employed: ☐Yes ☐No

Language: ☐ English ☐ Spanish ☐ French ☐ Other: ______________________________

Home Phone:_________________ Cell Phone:______________Work Phone:_______________

Home Address:____________________________________ City:_______________________

State:__________ Zip Code:_______________

Mailing Address:___________________________________ City:______________________
(if different than home address)

State:__________ Zip Code:_______________

Brief description of Injury/Condition/Amputation: ______________________________
____
____
____
____
____

Referring Physician:_________________________________ Phone:______________________

Primary Care Physician:______________________________ Phone:______________________

Spouse/Caregiver Information

Name:____ Relationship:__________________

Home Phone:________________ Cell Phone:________________Work Phone:______________

Emergency Contact *(Name of Closest Relative Not Living With You)*

Name:____Relationship:___________________

Home Phone:________________ Cell Phone:________________Work Phone:______________

Insurance Information

Primary Insurance

Provider:_______________________________

ID #:_________________________________

Group #:_______________________________

Responsible Party/Guarantor Information:

Name of Insured:_________________________

Relation to Insured:_______________________

SSN#:_________________________________

Address:_______________________________

City:________________ State:_____Zip:________

Phone:________________________________

Secondary Insurance

Provider:_______________________________

ID #:_________________________________

Group #:_______________________________

Responsible Party/Guarantor Information:

Name of Insured:_________________________

Relation to Insured:_______________________

SSN#:_________________________________

Address:_______________________________

City:________________ State:____Zip:________

Phone:________________________________

Disclosure of Information

I understand that my medical records and billing information are made a retained by Strive and are accessible to Strive personnel who may use and disclose medical information for Strive's operations and functions and to any other health care personnel involved in my continuum of care for this admission. During my visits to Strive, I will come in contact with other Strive patients who may be encouraged by my progress and whose progress may be encouraging to me. I do___ do not___ agree to the exchange of a limited amount of information about my case to be used to encourage others.

______________________________________ Patient (or Parent/Guardian) Name (printed) Date

______________________________________ Patient (or Parent/Guardian) Signature Date

______________________________________ Patient (or Parent/Guardian) Name (printed) Date

______________________________________ Patient (or Parent/Guardian) Signature Date

How Did You Hear About Us

☐ Primary Care Physician ☐ Nurse ☐ Friend ☐ Surgeon
☐ Physical Therapist ☐ Internet ☐ Hospital ☐ Case Manager
☐ Newspaper/Advertising ☐ Other______________________________

All of the information I have provided is true and correct.

______________________________________ Patient (or Parent/Guardian) Name (printed) Date

______________________________________ Patient (or Parent/Guardian) Signature Date

______________________________________ Patient (or Parent/Guardian) Name (printed) Date

______________________________________ Patient (or Parent/Guardian) Signature Date