

**VETERAN’S INFORMATION**

Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_ SS #: XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ □ Male □ Female Marital Status: □ Single □ Married □ Widowed □ Other

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

In the event we cannot reach you, contact - Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

**MEDICAL\_INFORMATION**

In case of emergency, contact person not living with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies to any contact materials? □ No □ Yes, please describe: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Diagnosed Medical Conditions:

□ Alzheimer’s or Dementia □ HIV □ Pulmonary Disease (TB) □ Hepatitis □ PTSD □ Other Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Taking Medication: □ Yes □ No Have had Major Surgeries: □ Yes □ No Height \_\_\_\_\_\_\_ Weight\_\_\_\_\_Lbs.

**CONSENT FOR TREATMENT,**

**AUTHORIZATION TO RELEASE INFORMATION**

**ACKNOWLEDGEMENT OF BILLING, WARRANTY, AND RETURN POLICIES**

I authorize treatment from Allen Orthotics & Prosthetics, Inc. to perform appropriate assessment and approve the treatment procedures recommended by the treating practitioner/s.

I authorize the release of any medical or other information to and from Allen Orthotics & Prosthetics, Inc. necessary to facilitate the care including, but not limited to, medical advice, treatment history, clinical records, diagnosis, and/or prognosis.

I acknowledge my understanding of General Billing, Warranty, and Return Policies.

I certify that the information provided by me is true, accurate, and complete.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Patient/Responsible Person’s Signature** **Date**

**HIPAA NOTICE AND ACKNOWLEDGEMENT**

I acknowledge that I have had the opportunity to review and/or obtain a copy of the facility’s Notice of Privacy Practices.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

**Patient/Responsible Person’s Signature** **Date**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**

Rev. 2022 Internal use only- received/reviewed by: \_\_\_\_\_\_\_\_

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