Texoma Orthotics & Prosthetics

Innovation Makes the Difference

Patient Information	**Today's Date:**				
Name:			Date of Birth:		
STREET Address:			SSN:	_____ - _____ - _____	
City, State, Zip:			Gender:	☐ Male ☐ Female	
Home Phone:		Work Phone:		Cell Phone:	
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced				
Employer:			Job Description:		
Email Address:					
MAILING Address:					

Height: _____ **Weight:** _____

Are you allergic to latex? ☐ **YES** ☐ **NO**

Emergency Contact			
Name:		Relationship:	
Phone:			

☐ **Tricare Benefits**	**Status:** ☐ Active Duty	☐ Retired	☐ Dependent
Sponsor Name:		Sponsor SSN	_____ - _____ - _____
☐ I have coverage other than TRICARE		Relationship to sponsor	
☐ **VA Benefits**			
SSN	_____ - _____ - _____		
☐ I have coverage other than VA		Company(ies)	

Office Use Only:			
Referring Provider			
Device			
Authorization/PO #			
Auth. Dates			
Other Info			

Brief Medical History:
Have you had or do you currently have any of the following conditions:

- ☐ Diabetes
- ☐ Insulin dependent diabetic
- ☐ Heart Problems
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Dialysis/Kidney Disease
- ☐ Osteoporosis
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Obesity
- ☐ Currently Pregnant
- ☐ Amputation(s): Level(s)_____
- ☐ Pulmonary Disease (TB)
- ☐ Ulcer/open wound on limb(s)
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Paralysis
- ☐ Staph Infection/ MRSA
- ☐ Seizures/ Epilepsy
- ☐ Parkinson Disease
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ PTSD
- ☐ Pacemaker/Defibrillator
- ☐ Other_____

List other known allergies (including contact materials):

_____

_____

Medications: ☐ I have a list that can be copied
Please list any medications that you are currently taking:

_____

_____

What is the primary reason for your appointment at our office? _____

_____

Are you having surgery relating to the reason you are being seen in our office? ☐ Yes ☐ No

If yes, please list the scheduled pre-op date and surgery dates, if known: _____

Did you have surgery relating to the reason you are being seen in our office? ☐ Yes ☐ No

If yes, when? _____, Surgeon(s)? _____