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			
Occupation:			Employer:	
Email Address:				
MAILING Address:				

Height: ________________ **Weight: ________________**

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

Emergency Contact			
Name:		Relationship:	
Phone:			

Referring Provider				**Primary Provider** ☐ (same as referring)			
Name:				Name:			
City, State		Phone:		City, State:		Phone:	

Primary Insurance					
Company		Policy #		Group #	
Policy Holder: (First & Last Name)		SSN	____ - _____ - _____	DOB	
		Relationship			

Secondary Insurance					
Company		Policy #		Group #	
Policy Holder: (First & Last Name)		SSN	____ - _____ - _____	DOB	
		Relationship			

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)? ______________________________

Legal Guardian / Power of Attorney ☐ **Not Applicable**			
Name:			
Relationship:			
Street Address:			
City, State, Zip:		Telephone:	