RENEW
PROSTHETICS & ORTHOTICS

146 Medical Park Rd. Suite 102
Mooresville, NC 28117
704-765-9837 / Fax 704-997-2679

PATIENT INTAKE FORM

PATIENT NAME: _____ GENDER: M / F DOB: ___/___/_____

PARENT/GUARDIAN (if patient is a minor): _____ SS #: _____

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: □ SINGLE □ MARRIED □ OTHER

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ MOBILE PHONE: (_____) _____

EMPLOYER: _____ EMPLOYER PHONE: (_____) _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ For internal use only. Will not be shared.

CONTACT INFORMATION:

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: (_____) _____ Authorization □ IS □ IS NOT granted to leave message(s).

PHYSICIAN INFORMATION

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

DIAGNOSIS: _____ ALLERGIES: _____

PLEASE ANSWER THE FOLLOWING:

Are you diabetic? □ YES □ NO Diabetic Physician: _____ Phone: (____) _____

Have you received a brace within the last 5 years? □ YES □ NO Describe: _____

Was this due to a work-related injury? □ YES □ NO When & Where: _____

Are you currently living in a skilled nursing facility? □ YES □ NO Name: _____

INSURANCE & BILLING INFORMATION:

PRIMARY INSURANCE: _____ POLICY ID #: _____ GROUP #: _____

SUBSCRIBER: _____ DOB: ___/___/_____

RELATIONSHIP TO SUBSCRIBER: □ SELF □ PARENT □ CHILD □ SPOUSE □ OTHER

SECONDARY INSURANCE: _____ POLICY ID #: _____ GROUP #: _____

SUBSCRIBER: _____ DOB: ___/___/_____

RELATIONSHIP TO SUBSCRIBER: □ SELF □ PARENT □ CHILD □ SPOUSE □ OTHER