ATLANTIC PROCARE

Welcome!

Thanks for taking the time to fill out this patient information.

Complete information is essential in providing the best care possible, assisting you with submitting claims to your insurance, and contacting you regarding your ongoing care. Thank you.

PATIENT INFORMATION — TODAY'S DATE >

Name _____ (First) _____ (Middle) _____ (Last) ☐ M ☐ F DOB _____

Identify as: _____ Marital Status _____ SS# _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Physical Address: Street, City, State, Zip: ☐ Same, or Street: _____

City _____ State _____ Zip _____

Preferred Phone _____ ☐ Cell ☐ Work ☐ Home (land)

Email Address _____ Active Military ☐ Yes ☐ No

Occupation _____ Employer _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

How did you hear about AtlanticProCare? _____

Who is here with you today? _____

Emergency Contact Information:

Name _____ Relationship _____ Phone _____

PARENT(S) OR GUARDIAN (for patients under age 18)

Name _____ DOB _____ SS# _____

Mailing Address: Street, City, State, Zip: ☐ Same, or : _____

Relationship to patient _____ Home Phone _____ Cell _____

Employer _____ Work Phone _____

Name _____ DOB _____ SS# _____

Mailing Address: Street, City, State, Zip: ☐ Same, or : _____

Relationship to patient _____ Home Phone _____ Cell _____

Employer _____ Work Phone _____

INSURANCE INFORMATION (please provide us with your insurance card(s) and any referral forms)

Policy Holder Name _____ DOB _____ SS# _____

Physical Address: Street, City, State, Zip: ☐ Same, or : _____

Relationship to patient _____ Home Phone _____ Cell _____

Employer _____ Work Phone _____

Primary Insurance _____ ID # _____

Secondary Insurance _____ ID # _____

Tertiary Insurance _____ ID # _____

DOES YOUR VISIT PERTAIN TO AN ACCIDENT ☐ Yes ☐ No Date of incident >

Insurance _____ Subscriber _____ Claim # _____

Address _____ Phone _____ Claim Adjuster _____

PATIENT MEDICAL INFORMATION

Patient current height: _____ Current weight: _____ Any recent changes in either? _____

Please describe why you are here: _____

_____

Date of onset of current problem or symptoms. Date _____

Have you received previous prosthetic or orthotic care? (Please list, including when and where)

_____ Date _____

PATIENT MEDICAL HISTORY

Do you have any of the following:

- ☐ Heart Problems
- ☐ Pacemaker/Defibrillator
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Vision Problems
- ☐ Pulmonary Disease (TB)
- ☐ Hearing Loss
- ☐ MRSA
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
  - Most recent A1C score: ____%)
- ☐ Osteoporosis
- ☐ Psychiatric Diagnosis
- ☐ Substance Abuse/Addiction
- ☐ Current Pregnancy
- ☐ Parkinson Disease
- ☐ Alzheimer's Disease
- ☐ Seizure Disorder
- ☐ Other

Any major surgeries? (Please list, including hospital and surgeon)

_____ Date _____

_____ Date _____

_____ Date _____

PERMISSIONS

From time to time, we reach out to patients on matters related to their care through all the means listed below. If there are any that you would prefer we NOT use to contact you, please check:

☐ Text ☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Mail (Home Address)

Please list the names of any persons who have your permission to receive information about your treatment, appointments and billing:

_____

_____

ACKNOWLEDGEMENT OF CONSENT, ASSIGNMENT AND RELEASE

Please **initial** each item below to acknowledge that you have read and understood the following:

_____ HIPAA Privacy Practices _____ Consent to Treat _____ Financial Agreement

_____ Medicare Supplier Standards _____ Release of Medical Information _____ Media Release

_____

Signature of Patient, Guardian or Personal Representative **Date**

_____

Type or print your name of Patient, Guardian or Personal Representative **Relationship**