(Diabetic Shoes/Inserts)

NEW HOPE PROSTHETIC & ORTHOTICS SERVICES, INC

PATIENT INFORMATION:

Today's Date: ___________ Patient Name: ____

If patient is a minor, please list the name(s) of parent(s) or legal guardian(s):

____ _____________________________________

Name & Relationship Name & Relationship

Date of Birth: ______________ Gender (circle): M F Soc Sec#: _______________________

Vocation (circle): Employed Student Homemaker Unemployed Disability Leave of Absence Retired

Patient's Employer: ___________________________________ Work Phone: (___)______________

Marital Status (circle): Single Married Divorced Widowed Spouse Name: ______________________

Home #: (___)______________ Cell #: (___)______________ Email: __________________________

Address: ___________________________________ City: ________________ State: ___ Zip: _______

Mailing Address (If different): ____

EMERGENCY INFORMATION:

Contact Name: _____________________________________ Phone #: __________________

Relationship to patient: _________________________________

INSURANCE INFORMATION: Self Pay ___

Primary Insurance: ____

Insurance ID #: _________________________________ Group #: ____________________

Name of Insured IF other than patient: ______________________________ Date of Birth: _________

Secondary Insurance: ____

Insurance ID #: __________________________________ Group #: _______________________

Name of Insured IF other than patient: _____________________________ Date of Birth: __________

PHYSICIAN INFORMATION:

Referring Physician: ____

Address: ________________________________ City: __________________ State: ___ Zip: _________

Phone: (___)___________________ Fax: (___)____________________

Physician who treats your diabetes: ____

Address: ________________________________ City: __________________ State: ___ Zip: _________

Phone: (___)___________________ Fax: (___)____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you currently taking medication to treat your diabetes? Yes __ No __

Have you received diabetic shoes and/or insoles within the past year? Yes __ No __

Do you authorize your practitioner to take photos or a video of you for your medical record? Yes __ No __

MEDICAL HISTORY: **(Diabetic Shoes/Inserts)**

General Health (check): Poor_ Fair_ Good_ Excellent_ Height: ____ Weight: ____ Shoe Size: _____

Patient currently has or had (check all that apply):

	Condition		Condition		Condition
	Heart Problems		Hepatitis C		MRSA
	Hypertension		Vascular Disease		Pacemaker/Defibrillator
	Osteoporosis		Rheumatoid Arthritis		HIV Positive
	Stroke		Osteoarthritis		Seizure Disorder
	Diabetes		Respiratory Disease		Hearing Loss
	Kidney Disease		Vision Problems		Currently Pregnant

Any other conditions not listed above: ____

List any known allergies (including contact materials): ______________________________________
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INSURANCE AUTHORIZATION AND MEDICAL RELEASE

I certify that the information provided is true, accurate and complete. I hereby authorize my insurance company(s), Medicaid and/or Medicare to pay directly to New Hope Prosthetic & Orthotic Svcs, Inc. all benefits due for services furnished by the aforementioned. Additionally, this authorization includes any secondary insurance coverage I currently have. I understand that for all charges not covered by insurance or any other source, including collection fees, I am financially responsible to New Hope Prosthetic & Orthotic Svcs, Inc. I authorize New Hope Prosthetic & Orthotic Svcs, Inc to obtain or release medical records to whomever they deem appropriate to facilitate my care. Patient confidentiality will be maintained. A photocopy of this agreement is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing.

HIPAA-Notice of Privacy Practices - This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

MEDICARE DMEPOS SUPPLIER STANDARDS - Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.

For your personal copy to review of the above forms, please ask for a printout.

_______________________________ ___________ ______________________________
Signature of Patient or Personal Representative Date Description of Personal Representative (if needed)