RELIABLE PROSTHETICS AND ORTHOTICS, LLC.

1505-C South Glenburnie Rd., New Bern, NC 28562 *P: 252-638-8989 / F: 252-638-5989*
12 Office Park Drive, Jacksonville, NC 28546 *P: 910-353-9002 / F: 910-353-9003*
229 Professional Circle, Morehead City, NC 28557 *P: 252-773-0046 / F: 252-773-0086*

GENDER: MALE / FEMALE _____ _____

SHOE SIZE **AGE** **HEIGHT** **WEIGHT**

__ __ __ __ __ __ __ __ __ - __ __ _____/_____/_____

BENEFIT ID NUMBER **DATE OF BIRTH**

(LOCATED BACK OF MILITARY ID)

_____ _____ _____

FIRST NAME **MI** **LAST NAME**

_____

ADDRESS *(IF BARRACKS, BUILDING AND ROOM # REQUIRED)* **CITY** **STATE** **ZIP**

(_____)_____ (_____)_____

HOME PHONE PREFERRED? ☐ **CELL PHONE** PREFERRED? ☐

DO YOU HAVE A SECONDARY INSURANCE ACTIVE (ALSO KNOWN AS "OTHER HEALTH INSURANCE")? ☐YES / ☐NO
IF YES:

_____

SECONDARY INSURANCE **POLICY HOLDER** **POLICY HOLDER D.O.B.**

Consent for treatment, release of Medical Information and Receipt of Notice of Privacy Practice:

PERSONS ABLE TO RECEIVE MEDICAL INFORMATION:

_____

_____

I, the undersigned, do hereby consent to treatment under the recommendations and the instructions of the Orthotist / Prosthetist.
I authorize any holder of medical or other information about me, to release such information as may be necessary for the completion of my treatment. A photo copy of this authorization is considered valid. I understand that I am responsible for all copayments, deductibles, and/or payments for services on claims which insurance benefits may be limited or non-existent.

By consenting to the procedure prescribed by my physician, and due to the inherent cost associated with custom fabrication, I understand that there can be no refund for custom fabricated orthotics or prosthetics, unless the item is proved to be substandard (less than full quality) or inappropriate at the time of fitting. By my signature below, I acknowledge that I have received the companies Notice of Privacy Practices, Patient Bill of Rights and Medicare Supplier Standards.

_____

SIGNATURE **DATE**

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INTAKE QUESTIONAIRE

The following questions are relating to the service(s) you are visiting us for. Please answer to the best of your ability. If you feel a section does not apply to you, please put "N/A".

1. Patient Name: _____

2. Have you recently been in contact with anyone with a COVID diagnosis? yes no

4. Current pain level: **1 2 3 4 5 6 7 8 9 10**

5. When did injury/symptom occur? _____

6. What activity caused your injury? _____

7. What are your symptoms? _____

8. What activities increase your pain level? _____

9. Have you had any surgical procedures pertaining to your visit today? If "yes", please explain: _____

_____

10. Any additional necessary info that pertains to your visit: _____

_____