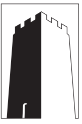

De La Torre Orthotics & Prosthetics, Inc.

Please fill out this form in its entirety. *THANK YOU!*

Patient Name: ______________________ Today's Date: ______________
Address: ______________________
City: ______________________ State: ________ Zip Code: ________
Social Security #: ______________________ Date of Birth: ______________
Home Phone #: ______________________ Work Phone #: ______________
Employer Name: ______________________
Address: ______________________
In case of emergency call (name): ______________________ Phone: ______________

MEDICAL INFORMATION:

Are you a diabetic? ☐ **Yes** ☐ **No** ***If YES, who is the physician treating your diabetes?*** ______________
Referring Physician Name: ______________________ **Phone # of**
Primary Care Physician: ______________________ **diabetic physician** ______________
Have you ever worn an orthosis/prosthesis previously? ☐ Yes ☐ No

Approx. height ________ weight ________
Allergies to materials and/or chemicals, plastics, glue, etc.: ______________________
Other medical history (ex: previous surgeries related to visit): ______________________

For prosthetics patients ☐ AK ☐ BK ☐ SYMES ☐ RIGHT ☐ LEFT
Date of amputation: ______________________ Reason for amputation: ______________________

INSURANCE INFORMATION:

Primary Insurance Company **SOCIAL SECURITY#:** ______________________
Address: ______________________
City: ______________________ State: ________ Zip Code: ________
Subscriber information (do not file in if same as patient information)
Name: ______________________ Date of Birth: ______________
Address: ______________________
City: ______________________ State: ________ Zip Code: ________
Relationship to patient: ______________________ Phone: ______________

Secondary Insurance Company **SOCIAL SECURITY#:** ______________________
Address: ______________________
City: ______________________ State: ________ Zip Code: ________
Subscriber information (do not file in if same as patient information)
Name: ______________________ Date of Birth: ______________
Address: ______________________
City: ______________________ State: ________ Zip Code: ________
Relationship to patient: ______________________ Phone: ______________

AUTO OR WORKERS' COMPENSATION:

Was this problem: Related to an **auto accident**? ☐ Yes ☐ No Related to a **work accident?** ☐ Yes ☐ No
Claim ID# ____________ Date of injury or accident: ____________ Social Security #: ____________
Claim adjuster name: ______________________ Phone number: ______________
Address of insurance carrier: ______________________
City: ______________________ State: ________ Zip Code: ________

PLEASE READ AND SIGN: "I request that payment of authorized medical benefits be made, when this option is available by insurance carrier, on my behalf to De La Torre Orthotics & Prosthetics, Inc. for any services rendered by the supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine.

Signature: **X** ______________________ Date: ______________

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