LIMBCARE Inc
PROSTHETICS & ORTHOTICS OF GEORGIA

Name:_____ **Date of Birth:** _____ **Age:** _____
Street Address: _____ **City:** _____ **State**: ____ **Zip:** _____
Social Security #: _____ **Drivers License #:**_____
Sex: M F **Marital Status:** S M D W **E-mail:** _____
Phone #: _____ **Alternative Phone #:** _____
Employer: _____ **Work Phone #:** _____
Employers Address: _____
Spouse or Parent Name: _____ **Phone #:** _____
Friend/Relative Not Living with You: _____ **Phone #:** _____
Primary (Regular) Physician: _____ **Phone #:** _____
Referring Physician: _____ **Phone #:** _____

What has been prescribed for you? (Circle those that apply)

Brace (Orthosis) Left Right Bilateral **Type of Brace:** _____

Artificial Limb (Prosthesis) Left Right Bilateral AK BK AE BE

Mastectomy Products Left Right Bilateral

Date & Reason for amputation: _____

Height: _____ **Weight:** _____

Is your condition the result of an accident or work-related injury? Yes No DOI: _____
If yes, please explain: _____

List any substance(s) you may have an allergic reaction to or any allergies you are aware of:
_____

List any other medical condition(s) that may affect the care we provide you: _____
_____

If the patient is a child or dependent, complete this section.
Person responsible for charges (if other than patient): _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Employer: _____ **Occupation:** _____
Relationship to patient: _____ **Home Phone#:** _____
Social Security #: _____ **Work Phone #:** _____

Patient's Employer: _____ **Phone #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Occupation: _____

Who can we thank for referring you to us?
Yellow Pages: _____ **Drove By:** _____ **Insurance Carrier:** _____ **MD:** _____
Friend/Relative (name): _____ **Other:** _____

Primary Insurance Information

Medicare #: _____ **Effective Date:** _____
Medicaid #: _____ **Effective Date:** _____
Insurance Company: _____ **Phone #:** _____
Address: _____
Group #: _____ **Member # or ID #:**_____

Secondary Insurance Information

Insurance Company: _____ **Phone #:** _____
Address: _____
Group #: _____ **Member # or ID #:**_____

Workman's Compensation Information

Employer: _____
Address: _____
Supervisor: _____ **Phone #:** _____
W/C Carrier: _____ **Phone #:** _____
Address: _____
Mail to: _____
Services Approved by: _____ **Date:** _____

Responsible Party/Subscriber Information

Insured's Name: _____
Relationship to Patient: __**Spouse** __**Parent** __**Other:** _____
Address: _____ **Phone #:** _____
Insured's Employer: _____ **Phone #:** _____
Employer's Address: _____
Insured's Social Security #: _____ **Date of Birth:** _____ **Sex:** M F

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Limbcare Prosthetics & Orthotics of Georgia for any services provided to me by Limbcare Prosthetics & Orthotics of Georgia. I herby assign, transfer, and set over to Limbcare Prosthetics & Orthotics of Georgia all of my rights, title, and interest of my medical reimbursement benefits under my insurance policy for services provided to me by Limbcare Prosthetics & Orthotics of Georgia. I authorize any holder of medical information about me to be released to determine these benefits. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I have read the financial policy presented to me and posted in the waiting room and agree to this financial policy.

Limbcare Prosthetics & Orthotics of Georgia takes their responsibility to protect your health information seriously. The "Notice of Privacy Practices" is available in the office for my viewing. With my Consent, Limbcare Prosthetics & Orthotics of Georgia may use and disclose Protected Health Information (PHI) in order to carry out treatment, payment and health care operations. With my consent, this office may also call my home and leave a message; send reminders/requests for appointment by mail; speak to other members of my household by telephone.

Signature: _____**Date:** _____

Medicare Patients Only: I have received a copy of the Medicare Supplier Standards: _____