51 E. Monterey Way
Phoenix, Arizona 85012
602-263-1010
fax: 602-263-7473

Patient Information

Please Print

Date: _______________

Patient's First Name: ____________________________ Middle: _______________ Last : ______________________________
Nick Name: _________________________ Date Of Birth: ____ / ____ / ____ Age: ____ Sex: M / F SS #: ____ - ____ - _____
E-Mail: ____

Employment (please circle): Full Time / Part Time / Unemployed / Student / Homemaker / Disability / Retired / Child

Driver License #: __________________________ State: _____ Marital Status: Single / Married / Divorced / Widowed / Other

Patient's Contact Information

If the patient is a child please list parent's names.

Father:___________________________________ Mother: ___________________________________
Home Phone: _____________________ Cell Phone: _____________________ Work / Other Phone: ____________________
Patient's Address: ____
City: ____ State: _________ Zip: _______________ Country: _________________
Person to Contact In Case of Emergency: ____ Phone: __________________

Responsible Party Contact Information

Parent / Guardian / Other: ____ Phone: ___________________
☐ If Same as Patient Address: ____
City: ____ State: _________ Zip: _______________ Country: _________________

Physical Therapist Contact

Name & Location: ____ Phone: ____________________

Patient Insurance Information

☐ Check Here If Patient is Self Pay ☐ Check Here If Patient has CRS

Is this a Worker's Compensation Case? Yes No
Is your condition a result of an accident from employment? Yes No
Is your condition a result of an auto accident? Yes No
Is your condition a result of any other type of accident? Yes No
Date of accident: ____ / ____ / ____ State accident occurred in: ______ Claim #: ____________________
Case Manager:____ Phone: ____________________

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Patient Insurance Information cont'd

Primary Insurance: ______________________________ Phone: ______________
Address: ______________________________ City: ____________ State: ____ Zip: ________
ID #: ______________________________ Group #: ______________ Plan #: __________
Insured's Name: ______________________________ DOB: ____ / ____ / ____ Relationship: __________
Employer of Insured: ______________________________ SS # of Insured: ____ - ____ - _____

Secondary Insurance: ______________________________ Phone: ______________
Address: ______________________________ City: ____________ State: ____ Zip: ________
ID #: ______________________________ Group #: ______________ Plan #: __________
Insured's Name: ______________________________ DOB: ____ / ____ / ____ Relationship: __________
Employer of Insured: ______________________________ SS # of Insured: ____ - ____ - _____

Tertiary Insurance: ______________________________ Phone: ______________
Address: ______________________________ City: ____________ State: ____ Zip: ________
ID #: ______________________________ Group #: ______________ Plan #: __________
Insured's Name: ______________________________ DOB: ____ / ____ / ____ Relationship: __________
Employer of Insured: ______________________________ SS # of Insured: ____ - ____ - _____

Information about your Insurance

Your insurance is a contract between you and your insurance carrier. Ultimately you are responsible for payment of your account with us .

We will submit claims to your insurance carrier when we are able to obtain telephone or electronic verification of eligibility with the insurance company.

We will do our best to obtain accurate information from your insurance company regarding your benefits so that you can make an informed decision about whether you want to receive services from us, however the information that the insurance company provides is NOT GUARANTEE OF PAYMENT.

We require that you pay any deductible and coinsurance payments for which you are responsible at the time of service.

______________________________ ____ / ____ / ____
Signature of Patient/Parent or Authorized Representative Date

Prescription Information

Reason for Visit: ______________________________ Prescription For: ______________
Diagnosis for Visit: ______________________________

Referring Physician: ______________________________ Phone: ______________
Primary Physician: ______________________________ Phone: ______________

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Patient Medical History

Please Print

Patient's Name: ______________________________ Date: ____ / ____ / ____

Allergies: ____

Height: ____________ Weight: ___________ Shoe Size: ___________ Activity Level: Low _____ Medium _____ High _____

General Overall Health: Poor / Fair / Good / Excellent

Have you received any orthotic or prosthetic devices within the past year? Yes / No

If YES please list the dates and description of the devices.

(/ /) ____

(/ /) ____

(/ /) ____

Please check all that apply to your medical history:

- ☐ Seizures
- ☐ Autism
- ☐ Heart Problems
- ☐ Hypertension High Blood Pressure
- ☐ Vascular Disease
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Hepatitis A or B
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pulmonary Disease (TB)
- ☐ Vision Problems
- ☐ Pregnant
- ☐ Amputation
  Where? ____________
- ☐ Neuropathy
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ Obesity
- ☐ Allergies to contact materials
  ____
  ____
  ____
  ____

Please list the dates and descriptions of past surgeries or Botox injections:

Date	Description
(/ /)	
(/ /)	
(/ /)	

Please inform your practitioner of any medications you are taking that are related to your visit.

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