

Hi-Tech Artificial Limbs, Inc.
Patient Intake Form

Section 1 - Patient Information

Patient Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth _____ Age _____ Sex: Male / Female SSN: _____ Email: _____

Vocation : ___Employed ___ Student ___ Homemaker ___ Unemployed ___ On Disability ___ Retired ___ Child

Drivers License # _____ Marital Status ___ Single ___ Married ___ Divorced ___ Widowed

Home Phone: _____ Work Phone: _____ Cell Phone _____

Home Address: _____ City _____ ST _____ Zip _____

Work Address: _____ City _____ ST _____ Zip _____

Mailing Address (if different from Home Address) _____ City _____ ST _____ Zip _____

Section 2 - Contact Information

Spouses Name: _____ Work Phone _____ Cell Phone _____

Emergency Contact: _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Section 3 - Insurance/Payment Info

Do you have Insurance? ___ Yes ___ No If No, person responsible for Account _____

Primary Insurance _____ ID # _____ Grp # _____ Plan _____

Relationship of Patient to Insurance Subscriber ___ Self ___ Spouse ___ Child

If Spouse or Child, Please Provide Primary Subscriber Info:

First Name _____ Last Name _____

Date of Birth _____ SSN _____

Address _____ City _____ ST _____ Zip _____

Secondary Insurance _____ ID # _____ Grp # _____ Plan _____

If Work Related, Workman Comp Carrier _____

Adjuster's Name _____ Phone _____

Section 4 - Medical Information

Type of Amputation: ___ Right Side ___ Left Side ___ Bilateral

___ Above Knee ___ Below Knee ___ Above Elbow ___ Below Elbow

Date of Amputation: _____ Is your condition a result of ___ Accident from Employment ___ Auto Accident

___ Other Accident _____ ___ Congenital ___ Other _____

Currently wearing a prosthesis? Yes / No If yes, how long have you been wearing your current limb? _____

When was your most recent limb made? _____ Where was it made? _____

Height: _____ **Weight:** _____ Do you lift or carry over 30 pounds at work or home? Yes / No

Please check any of the following conditions that apply ___ Heart Problems ___ Hypertension ___ Vascular Disease

___ Stroke ___ Diabetes ___ Kidney Disease ___ Hepatitis A or B ___ HIV Positive ___ Rheumatoid Arthritis

___ Osteoarthritis ___ Pulmonary Disease (TB) ___ Vision Problems ___ Parkinson Disease ___ Alzheimer Disease

___ Psychiatric Problems ___ Alcoholism ___ Allergies to contact materials/Latex Allergy ___ Obesity

List any other conditions that you feel might affect your treatment _____

Currently taking medications _____

Do you have a physician's prescription for a prosthesis? ___ Yes ___ No

Primary Care Physician _____ Tel # _____

Referring Physician _____ Tel # _____

Are you diabetic? Y / N Physician Managing Diabetes _____ Tel # _____

Section 5 - Comments & Referral Source

What would you like to do with your Hi-Tech prosthesis? _____

Do you have any questions, special needs or information you would like from us? _____

How did you hear about Hi-Tech? ___ Physician Referral (name) _____

___ Cardinal Hill Amputee Clinic ___ Physical Therapist (name) _____

___ Friend (name) _____ ___ Hi-Tech Employee (name) _____

___ Yellow Pages (city) _____ ___ Web Site ___ Drove by (Saw Sign)

___ TV Ad (Channel) _____ Other _____