Patient Intake Form

Evergreen Prosthetics & Orthotics

Patient Information

Patient Name (First, Middle Initial, Last): _____

Preferred Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City/State/Zip: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Shoe Size: _____

Employer: _____ Work #: _____

Contact Information

Cell #: _____ Home #: _____ Email Address: _____

Preferred Method of Contact for reminders: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Call ☐ Text ☐ Email

Any restrictions in contact: _____

Emergency Contact (Name, Relationship, Phone Number): _____

General Medical Information

Referring Physician (Name and Phone): _____

Primary Care Physician (Name and Phone): _____

Have you had a similar device to the one you will be receiving? ☐ No ☐ Yes, from: _____

If yes, when did you receive this device? Month/year: _____ Do you still have the device? ☐ No ☐ Yes

Are you diabetic? ☐ No ☐ Yes If yes, list MD or DO who treats your diabetes: _____

Are you currently staying in a Medicare covered skilled nursing facility or hospice care? ☐ No ☐ Yes

If yes, name of facility: _____ Contact Person/Phone: _____

Insurance Information

Primary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name (if other than patient): _____ Subscriber Date of Birth: _____

Complete this section if your injury is related to one of the following (please mark):

☐ Work Injury ☐ Motor Vehicle Accident ☐ Other Liability

Insurance Name: _____ Claim #: _____

Date of Injury/Accident: _____ Adjuster Name & Phone #: _____

More on reverse

Assignment of Benefits, Consent to Contact & Notice of Financial Responsibility

I authorize Evergreen Prosthetics & Orthotics, LLC (Evergreen) to bill insurance(s) for payment of services rendered to myself or any policy dependents. Any quote of coverage or potential financial responsibility given by an Evergreen employee is not a guarantee and is subjected to change and will ultimately be based on the processing of the claim by your insurance provider. I agree to provide Evergreen with my correct billing and contact information or I may be responsible in full for any charges incurred. I give consent to Evergreen and its employees to contact me either by phone, mail or e-mail regarding services provided or new services that could benefit me. You may opt out of this consent to allow contact at any time. I agree that any returned checks will accrue a charge of $25 for each occurrence. I understand that I am ultimately responsible for the balance of my account or the account(s) of my dependents and agree to pay in a timely manner.

☐ I would like to receive marketing messages about products and services offered by Evergreen

Patient Signature: _____ Date: _____

Guardian/Legal Representative Name: _____ Relationship to Patient: _____

Guardian/Legal Representative Signature: _____ Date: _____

HIPAA Documents & Supplier Standards Receipt

I certify that I have reviewed and I agree to the terms listed within the documents listed below. I also understand that a copy of these documents has been made available to me upon request.

Document Description
HIPAA Consent Form
Notice of Privacy Practices
Medicare Supplier Standards

Patient Signature: _____ Date: _____

Guardian/Legal Representative Name: _____ Relationship to Patient: _____

Guardian/Legal Representative Signature: _____ Date: _____

How did you hear about us?

☐ I was directly referred by my physician or another provider (name): _____

☐ Evergreen was referred to me by a friend (name): _____

☐ Web Search ☐ Social Media (site): _____ ☐ Review Site (site): _____

☐ Magazine or Newspaper (name): _____ ☐ Other: _____