Section 1-Patient Information

Patient Name (Last, First, MI):_____

SSN:_____ Date of Birth:_____ Driver's License : _____ State:_____
Sex: Male / Female Marital Status: Single / Married / Widowed / Other

Home Tel #:_____ Work Tel #:_____ Mobile #:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Mailing Address::_____ City:_____ State:_____ Zip:_____

Email Address: _____

Employed Retired Disabled Pediatric Patient Unemployed
Patient's Employer:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ SSN:_____ Date of Birth:_____

Section 2-Parent / Guardian / Responsible Party

Name (Last, First, MI):_____

SSN:_____ Date of Birth:_____ Driver's License : _____ State:_____
Relationship to Patient: Spouse / Parent / Guardian / Other (Explain) _____

Employer:_____ Tel #: _____

Employer's Address:_____ City:_____ State:_____ Zip:_____

****DIVORCED PARENTS PLEASE NOTE:** It is the policy of this office the parent **accompanying** the child for treatment will be heal responsible for all incurred expenses. We cannot bill the other parent.**

Section 3 – Emergency Contact

Name (Last, First, MI):_____
Work Tel #:_____ Home Tel #:_____ Relationship:_____

Section 4 – Insurance Information

Is this a Worker's Comp Claim? Y / N (if Yes, please complete WORKER'S COMP form)

Primary Insurance: _____	Secondary Insurance: _____
Policyholder: _____	Policyholder: _____
Policyholder DOB: _____	Policyholder DOB: _____
Policyholder SSN: _____	Policyholder SSN: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____
Tel #: _____	Tel #: _____
Relationship to Policyholder: _____	Relationship to Policyholder: _____

MAHAFFEY
ORTHOTICS & PROSTHETICS

CONSENT TO RELEASE MEDICAL RECORDS

Patient Name _____

Date of Birth _____

I hereby authorize and request that

_____

(Name of Referring Physician)

Release information from my medical records to the following:

MAHAFFEY ORTHOTICS & PROSTHETICS

(Name of Facility Providing Services)

I give my consent to the release of above-mentioned information and understand that my consent is subject to revocation at any time. This consent will expire 60 days after the date of the signature.

_____

Signature of Patient/Guardian

_____

Date of Signature

_____

Signature of Witness

6103 W. Amarillo Blvd · Amarillo, Texas 79106 · Office 806.358.2343 · Fax 806.358.2920

Financial Responsibility:

All professional services rendered are charges to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits:

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Mahaffey Orthotics & Prosthetics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization for Release of Information:

I hereby authorize Mahaffey Orthotics & Prosthetics to: (1) release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Mahaffey Orthotics & Prosthetics on behalf of myself and/or my dependents, and understand that by making this requires I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Photograph Release:

I hereby authorize and ratify any photographing of myself (or of the above named patient) by Mahaffey Orthotics & Prosthetics in connection with diagnosis and treatment as determined by the attending practitioners and any consultants, and for scientific and educational purposes. (Photographs may be used for visual presentations in physician, medical student, and ancillary health educational training programs, may be incorporated with the patient's medical record for documentation of care, and may be used in conjunction with articles in medical or scientific publications.) My name (or the name of the aforementioned patient) shall not be used to identify said photographs, outside of the medical record.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Relationship

Medical History

Patient Name:_____ DOB:_____

Height: _____ Weight:_____ Recent Changes in Weight: Gain Lost _____Lbs

Date of Onset/Illness/Injury/Amputation:_____

Affected Side: Left Right Bilateral Level of amputation:_____

Referring Physician:_____

Are you diabetic? Yes No Physician Managing Diabetes:_____

General Health: Excellent Good Fair Poor

Activity Level: Highly Active Active Medium Low

Patient currently has or has had (Check if yes):					
	Heart Problems		Hepatitis C		Alzheimer Disease
	Hypertension		HIV Postive		Psychiatric Problems
	Vascular Disease		Rheumatoid Arthritis		Alcoholism or Drug Abuse
	Stroke		Obesity		Pacemaker/Defibrillator
	Diabetes		Oseoarthritis		Seizure Disorder
	Kidney Disease		Pulmary Disease (TB)		Hearing Loss
	Osteoporosis		Vision Problems		Currently Pregnant
	Hepatitis A or B		Parkinson Disease		MRSA

List any other conditions that may affect your treatment:_____

_____

Allergies (including contact materials such as Latex or adhesives):_____

_____

Current Medications:_____

_____

Any changes in Medical History or Prescriptions since last visit:_____

_____

Are you currently in the same or similar device? Yes No

If yes, age of device: New Under 2 years 2-5 Years 5-10 Years Over 10 Years

	Excellent	Good	Fair	Poor
Condition of device				
Fit				
Function				
Cosmesis				
Overall				
Satisfaction				

_____ _____

Signature Date