

## PATIENT INTAKE FORM

Social Security # Date of Birth Sex: Male Female Permanent Address  City State Zip Home phone (	Patient Name (Last, First, MI)				
City	Social Security #	Date of Birth	Sex: Male	Female	
Home phone (	Permanent Address				
Employer Name and address  Primary Insurance  Insurance Company Name  Group Name/Number	City	State	Zip		
Primary Insurance Insurance Company Name Group Name/Number	Home phone ()	Work phone	()		
Insurance Company Name Group Name/Number	Employer Name and address				
Group Name/Number	<b>Primary Insurance</b>				
Group Name/Number	Insurance Company Name				
Social Security # Date of Birth Relationship to Patient					
Employer Name and Address	Subscriber's Name (Last, First, M	ſI)			
Secondary Insurance Insurance Company Name Group Name/Number	Social Security #	Date of Birth	Relationship to Patient _		
Insurance Company Name	Employer Name and Address				
Group Name/Number					
Subscriber's Name (Last, First, MI)	Insurance Company Name				
Social Security # Date of Birth Relationship to Patient Employer Name and Address Date of Injury is work-related, please answer the following:  Employer at time of Injury Date of Injury Date of Injury Phone# ( )  Workers' Comp Insurance Name & Address Phone# ( )  Workers' Comp Insurance Name & Address Phone# ( )  Have you ever had a similar device to the device you will be receiving from us? Yes No    If yes, when did you receive this device? Month /Year Do you still have the device?    How was this device paid for? Medicare Self-pay Received in hospital Insurance (If so, which insurance company? )  Are you currently staying in a Medicare-covered bed at a skilled nursing facility? Yes No    How did you hear about Streamline Orthotics, LLC?    I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information.	Group Name/Number	ID#			
Employer Name and Address  If injury is work-related, please answer the following:  Employer at time of Injury Date of Injury	Subscriber's Name (Last, First, M	ſI)			
If injury is work-related, please answer the following:  Employer at time of Injury	Social Security #	Date of Birth	Relationship to Patient _		
Employer at time of Injury	Employer Name and Address				
Employer Address	If injury is work-related, please	e answer the following:			
Employer Address	Employer at time of Injury	Date of Injury			
Name of Case ManagerPhone# (					
Name of Case ManagerPhone# (	Workers' Comp Insurance Name	& Address			
If yes, when did you receive this device? Month /Year Do you still have the device? How was this device paid for? Medicare Self-pay Received in hospital Insurance (If so, which insurance company?)  Are you currently staying in a Medicare-covered bed at a skilled nursing facility? Yes No How did you hear about Streamline Orthotics, LLC? I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information.					
How was this device paid for? Medicare Self-pay Received in hospital Insurance (If so, which insurance company?)  Are you currently staying in a Medicare-covered bed at a skilled nursing facility? Yes No  How did you hear about Streamline Orthotics, LLC?  I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information.	Have you ever had a similar de	vice to the device you will be recei	ving from us? Yes	No	
Insurance (If so, which insurance company?)  Are you currently staying in a Medicare-covered bed at a skilled nursing facility? YesNo  How did you hear about Streamline Orthotics, LLC?  I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information.	If yes, when did you receive this	device? Month /Year	Do you still have the	device?	
Are you currently staying in a Medicare-covered bed at a skilled nursing facility? YesNo	How was this device paid for?	Medicare Self-pay	Received in hosp	oital	
How did you hear about Streamline Orthotics, LLC?  I hereby certify that the information I have provided above is complete and accurate. If I am the patient's representative, I certify that I am duly authorized on behalf of the patient to provide this information.	Insurance (If so, w	hich insurance company?		)	
I hereby certify that the information I have provided above is complete and accurate. If I am the patient's repretative, I certify that I am duly authorized on behalf of the patient to provide this information.	Are you currently staying in a M	Medicare-covered bed at a skilled	nursing facility? Yes _	No	
I hereby certify that the information I have provided above is complete and accurate. If I am the patient's repretative, I certify that I am duly authorized on behalf of the patient to provide this information.	How did you hear about Stream	nline Orthotics, LLC?			
Signature of Patient Date	tative, I certify that I am duly aut	horized on behalf of the patient to p	rovide this information.		
Signature of Patient Date					
Date Date	Signature of Patient		Date		
	orginature of a autilit		Date		
Signature of Parent/Guardian/Authorized Representative Relationship to patient	Signature of Parent/Guardian/Aus	thorized Representative	Relationship to patie		