Patient Information

Last______________________________First_________________________Middle____________________Male____Female____

Date of Birth_______________________ Social Security #____

Email Address____

Mailing Address____

City_____________________________________State__________________________Zip Code_____________________________

Home Phone______________________________Work_____________________________Cell_______________________________

Occupation____ Marital Status____

Parent or Legal Guardian (if Minor) ____Phone______________________________

Street Address if Different____

City_____________________________________State______________________________Zip Code_____________________________

Person to notify in case of an Emergency:

Name____Phone________________________Relationship________________________

Are you an Amputee? Yes No Date of Injury__________________ Date of Amputation_______________________

Primary Care Physician_________________________________Diabetic Physician__________________________________

Referring Physician____

Insurance Information

Primary Insurance: ______________________________ Policy#:_______________________________________

Name of Insured: ____ DOB: ______________________________

Relationship to patient: Self: ____________ Other: __________

Secondary Insurance ______________________________ Policy#:_______________________________________

Name of Insured: ____ DOB: ______________________________

Relationship to patient: Self____________ Other: __________

Compound Authorization for Release of Information

Please check either "Yes" or "No" and initial each line. **Do you authorize Prosthetic and Orthotic Institute to:**

1. Mail medical reports through US Postal Service? ____ Yes ____ No _____Initial
2. Leave a message on Voice Mail? ____ Yes ____ No _____ Initial
   Cell Phone Number ______________________________
3. Leave a message on Answering Machine? ____ Yes ____ No _____ Initial
   Home ________________________ Work ______________________________
4. Give information to your employer? ____ Yes ____ No _____ Initial
   Name ______________________________
5. Give information to your school? ____ Yes ____ No _____ Initial
   Name ______________________________
6. Give information to your spouse? ____ Yes ____ No _____ Initial
   Name ______________________________
7. Give information to your parents? ____ Yes ____ No _____ Initial
   Name ______________________________
   Name ______________________________
8. Give information to your children? ____ Yes ____ No _____ Initial
   Name ______________________________
   Name ______________________________
   Name ______________________________
9. Give information to friends or others? ____ Yes ____ No _____Initial
   Name ______________________________
   Name ______________________________

Rights of the Patient

1. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by signing a written notification to **Prosthetic and Orthotic Institute HIPAA Officer.**
2. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
3. I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
4. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Print Name of Patient ______________________________

Patient (guardian) Signature ______________________________ Date ______________

POI Employee ______________________________ Time ______________