Name:_______________________________________Date of Birth:_________________________________

Social Security#___________________________ Sex: ☐ Male ☐ Female

Physical Adress:_____________________________ City/State/Zip:__________________________________

Mailing Address If Different from Physical Address:____

Home Phone:_____________________________ Cell Phone:_______________________________________

Work#___________________________________ Is it ok to contact you at work? ☐ Yes ☐ No

Parent or Guardian (If Applicable)__________________Relationship__________ Phone#______________

Emergency Contact Name:___________________ Relationship:_____________ Phone#______________

Referring Doctor:_________________________

Are you currently or have you ever worn a brace or prosthesis? ☐ Yes ☐ No

If "Yes" when:________________________________ Please identify what type below

☐ Diabetic Shoes ☐ Back Brace ☐ Knee Brace ☐ Neck Brace ☐ Prosthesis ☐ Other

To your knowledge, is your physician planning to perform surgery on you within the next 4 weeks?

☐ Yes ☐ No If "Yes", when? Date of Surgery:________________ Hospital:_____________________

Have you recently had a MRI or XRAY? ☐ Yes ☐ No If "yes" type and date:______________________

Are you diabetic? ☐ Yes ☐ No If "Yes" please provide us with the doctor name and information that treats your diabetes below.

Physicians Name:_____________________________ Phone#___________________________________

Physicians Address:____

Is this a workers compensation injury? ☐ Yes ☐ No – If yes, please complete box below

Was this an on the Job Injury?____________ Date of Injury:____________ Claim#__________________

Carrier Name:________________________________ Adjuster:__________________________________

Carrier Address:____

Adjuster's Phone#:________________________ Employer at time of injury_________________________

Please provide all insurance coverage below. If you need an additional form please let us know

Primary Insurance
Insurance Company Name:
Policy holder's name:
Relation to policy holder:
Policy holder date of birth:
Insurance Identification#

Secondary Insurance
Insurance Company Name:
Policy holder's name:
Relation to policy holder:
Policy holder date of birth:
Insurance Identification#

HIPPA RELEASE/PAYMENT POLICY

I hereby authorize Neu Limbs, DBA Hill Country Orthotics & Prosthetics to furnish information to any State or Federal agency, insurance carrier, or physician for the purpose of treatment, payment or healthcare operations. My signature assigns benefits to Hill Country Orthotics & Prosthetics to bill legitimate insurance and/or Medicare claims on my behalf for the duration of my treatment. I authorize Neu Limbs, DBA Hill Country Orthotics and Prosthetics, to obtain and/or release any medical condition/treatment documentation necessary for the purpose of processing my claims. I understand and agree that if for any reason my insurance carrier(s) denies payment to Neu Limbs, DBA Hill Country Orthotics and Prosthetics, that I will be responsible for paying any balances not covered by my insurance(s).

I have been provided the opportunity to review the HIPPA and Notice of Privacy Practice. I agree that a representative of Hill Country Orthotics & Prosthetics may contact me at the phone numbers I have listed and I may also be contacted by mail in the form of a postcard or mail-out

____ _________________________

Signature of patient/guardian (Today's Date)

____

Printed name of patient/guardian