Rogerson Orthopedic Appliances– Patient Registration/Intake Form

***Patient Account No (office use)*: _____**

Today's Date: _____

Patient Full/Legal Name: _____ _____ _____
(First Name) (MI) (Last Name)

DOB: _____/_____/_____ Social Security# _____-_____-_____ ☐ Male ☐ Female

Permanent /Legal Address: _____

City: _____ State: _____Zip Code: _____

Home Phone: _____ Work: _____ Cell:_____

Email: _____ Marital Status:_____

Occupation: _____Employer:_____

Employer Address & Phone: _____

Parent/Guardian Name: _____Phone:_____

Emergency Contact Name: _____Phone: _____

PLEASE ATTACH YOUR INSURANCE CARDS AND A PHOTO ID:

(Office Use) Photo ID Verified: _____
(initials)

Type of Insurance & ID No:

- ☐ **Medicare _____**
- ☐ **Blue Cross _____**
- ☐ **Tufts Health_____**
- ☐ **BMC HealthNet_____**
- ☐ **MassHealth_____**
- ☐ **HPHC_____**
- ☐ **NHP_____**

☐ **Other Insurance Name:_____ ID No:_____**
Group#_____ Phone:_____

Subscriber: _____ Relationship:_____

Are you here today because of an injury from an accident: ☐ YES ☐ NO

☐ **Workers Comp** ☐ **Auto Accident** ☐ **Other Accident** **Date of Injury:_____**

Claim/File# _____ Insurance Co:_____

Phone:_____ Contact Person: _____

Employer: _____

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Patient Status/Medical History: ***Patient Account No (office use):*** **_____**

Patient Name: _____Todays Date:_____

Nature of illness/injury you are being referred for: _____

Date of Onset: _____Are you diabetic: _____

Is your injury: _____work related _____auto accident other:_____

***Have you had any previous orthoses (braces or supports) or prostheses (artificial limbs) prior to today from any other providers, if yes please describe device and date(s) of other service(s):**

_____

_____

Current Living Status:

____@home w/out assistance _____@home w/assistance

____Long Term Care Facility _____Rehab or Skilled Nursing Facility

Assistive Devices: _____Cane _____Walker _____Crutches _____Wheelchair

Height:_____ Weight: _____

Please list any other medical conditions or current medications we should be aware of that could affect the care we provide you:

_____

_____

_____

List any material or substance allergies or allergic reactions you are aware of (i.e., latex):

_____

_____

PCP Name: _____Phone:_____

Referring Physician: _____Phone:_____

Other (PT/OT,RN): _____Phone:_____

Rogerson Orthopedic Appliances– Patient Registration/Intake Form

Patient Status/Medical History: **Patient Account No: (office use) _____**

Patient Name: _____ **Todays Date**: _____

Nature of Condition: ☐illness ☐work accident ☐auto accident ☐Congenital (from Birth)
☐other _____ Accident Date: _____

General Health: ☐Excellent ☐Good ☐Fair ☐Poor

Height: _____ Weight: _____ Recent Weight Changes: + or - _____how much

Have you had or do you have any of the following?

☐Heart Problems	☐Hepatitis A or B	☐Vision Problems	☐Pacemaker/Defibrillator
☐Hypertension	☐Hepatitis C	☐Parkinson Disease	☐Seizure Disorder
☐Vascular Disease	☐Alzheimer Disease	☐Hearing Loss	☐Stroke
☐Diabetes	☐Arthritis	☐Obesity	☐MRSA
☐Kidney Disease	☐Osteoarthritis	☐Osteoporosis	☐Pulmonary Disease
☐Tuberculosis	☐Neuropathy	☐Poor Sensation	☐Rheumatoid Arthritis

List any medications or other conditions that we should be aware of that may affect the care we provide you (swelling, dizziness):_____

_____

Please list material or substance allergies or reactions you are aware of (i.e., latex):

_____

Current Living Status: ☐@ home independently ☐@ home with assistance
☐Skilled Nursing Facility ☐Long Term Care
☐other _____

Assistive Devices: ☐Cane ☐Crutches ☐Walker ☐Wheelchair (manual or electric)

Have you had any previous orthotic or prosthetic devices (braces or limbs) **prior to to-day? If yes when, where and what did you receive**: _____

_____

_____

Primary Care Physician: _____Phone No: _____