UNION ORTHOTICS & PROSTHETICS CO.
PATIENT INTAKE

Patient Last Name _____ Patient First Name _____

Date of Birth _____ ☐ Male ☐ Female Social Security #_____

Cell Phone _____ Home Phone _____

Work Phone _____

Address_____

City_____ State_____ Zip_____-_____

Referring Physician _____ Primary Care Physician _____

Parent/Guardian _____ Parent/Guardian Date of Birth _____

★ Please provide us with your email so we can email you an online survey to tell us how we are doing. Your email will be kept strictly confidential. We will not initiate any type of communication with you via this email address.

*Email _____

Please check which type of health insurance you have: ❒ Group Plan through Employer ❒ Individual Plan I pay for monthly

Is the reason for your visit due to a work-related injury? ❒ No ❒ Yes If yes, what was your date of injury? _____

If yes, please provide us with additional information: **Employer** _____

Carrier _____ **Claim #** _____ **Phone** _____

Please complete with current health insurance information
It is important we have your current insurance information or you may be responsible for payment.
If you have applied for Medicaid, be sure to let us know.

★**Primary Insurance** _____ ID Number _____

Subscriber _____ **Subscriber Date of Birth**_____

Primary Insurance Phone _____ (if a copy of your card was not taken)

Secondary Insurance _____ ID Number _____

Subscriber _____ **Subscriber Date of Birth**_____

Secondary Insurance Phone _____ (if a copy of your card was not taken)

This form was completed by _____ Date _____