EXPRESS
ORTHOTICS & PROSTHETICS

Shane Wakefield, CPO/LPO
Licensed Prosthetist/ Orthotist # POR249

PATIENT INFORMATION

Date: ___/___/_____

Section 1 – Patient's Information:

Patient's Name: (Last, First, MI):____

SSN: ____/____/ _____ DOB: ___/____/_____ Age:_____

Sex: M/F Marital Status: S/M/W/D

Home Address: ________________________________ APT #: ______________

City: ____________________________State: ____ Zip: ________

Cell #: (_____) ______- _________ Home #: (_____) _______-_______

Email Address: ____

Patient's Employer: ____

Employer Address: ____

City: __________________ State: _______ Zip: ____________

Work#: (_____) ______- _________ Fax #: (_____) _______-_______

Section 2- Prescribing Physician:

Doctor: ____

Street: ____

City: __________________ State: _______ Zip: ____________

Phone #: (______) ______- _________ Fax#: (_____) ______- __________

Section 3- Referral Source: ____

Section 4 – Spouse/Parent/ Guardian/Responsible Party/Emergency Contact

Name: (Last, First, MI): ______________________________________

SSN: _____/_____/ ______ DOB: _____/_____/_____ Age: _______

Relationship to Patient: ______________________________________

Street: ____________________________________APT# ____________

City: ________________________ State: ______________ Zip: __________

EXPRESS
ORTHOTICS & PROSTHETICS
Shane Wakefield, CPO/LPO
Licensed Prosthetist/ Orthotist # POR249

Section 5 - Insurance

Primary Insurance: ______________________________
Address: ____ Suite #: ________
City: _________________________State: __________ Zip: ______________
Phone#: (______) ______-_________
Policyholder: _______________________ Relationship: ___________________
Policyholder DOB: ____/_____/______ SS#: ____/_____/______
ID #: _____________________ Group # _______________________
Case Manager: ______________________ Phone#: (______) ______-_________

Secondary Insurance: ___________________________________
Address: _____________________________________ Suite: __________
City: ______________________ State: ___________ Zip: ____________
Phone#: (_______) _______-__________
Policyholder: ____________________ Relationship: ___________________
Policyholder DOB: ____/_____/_______ SS#: ____/_____/______
ID #: _______________________ Group # _____________________
Case Manager: ________________ Phone#: (______) ______-_______

Workman's Compensation: Y / N
Date of Injury _____/______/______ Is this due to an auto/home accident? Y / N
Location of accident: ____
Insurance: __________________________ Policy #: _____________________
Address: ____
City: _________________________State: __________ Zip: ______________
Phone#: (______) ______-_________ Fax#: (______) ______-_________
Contact Person: ____

I hereby request Express Orthotics & Prosthetics, Inc. to provide any prosthetic/ orthotic services necessary, per my physician's prescription.

Patient/Responsible Party:____
Signature: ________________________________ Date: ________________