DYNAMIC
ORTHOTIC & PROSTHETIC
SERVICES, INC

Main Office: 103 E. Pinhook Rd
Lafayette, LA 70501
T. 337-291-1016 F. 337-704-0324

PATIENT INFORMATION

_____ ___/_____/_____ Sex: ☐ M ☐ F
Last Name First Name MI DOB

_____ _____
Social Security # Email ** By entering my email, I give DOS consent to communicate via email**

Check all that apply: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

☐ Employed Full Time ☐ Employed Part Time ☐ Student Full Time

☐ Student Part Time ☐ Unemployed ☐ Disabled ☐ Retired

_____ ☐ Call 1st _____ ☐ Call 1st _____ ☐ Call 1st
Home Phone Cell Phone Work Phone

Check which number(s) we may leave a message on: ☐ Home ☐ Cell ☐ Work ☐ Other_____

_____ _____ _____ _____
Mailing Address City State Zip

_____ _____ _____ _____
Home Address ☐ Same as above City State Zip

_____ _____ _____
Emergency Contact Phone Relationship to Patient

_____ _____ _____
Parent or Guardian (if patient is minor) Phone Relationship to Patient

RESPONSIBLE PARTY

☐ Same as Patient

_____ ___/_____/_____ Sex: M☐ F☐
Last Name First Name MI DOB

_____ _____
Social Security # Email ** By entering my email, I give DOS consent to communicate with me via

_____ ☐ Call 1st _____ ☐ Call 1st _____ ☐ Call 1st
Home Phone Cell Phone Work Phone

_____ _____ _____ _____
Mailing Address ☐ Same as Patient City State Zip

_____ _____ _____ _____
Home Address ☐ Same as Patient City State Zip

Who may we thank for telling you about our office? _____

-OVER-

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COMMUNICATION CONSENT

Please list who we may contact or speak with besides the patient, parent or guardian:

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

PRIMARY INSURANCE INFORMATION

Insurance Company_____Policy #_____

Name of Insured_____Relationship to Patient_____

Birthdate_____ Social Security #_____ Employer_____

Subscriber's Address_____City_____State____ Zip_____

SECONDARY INSURANCE INFORMATION

Insurance Company_____Policy #_____

Name of Insured_____Relationship to Patient_____

Birthdate_____Social Security #_____ Employer_____

Subscriber's Address_____City_____State____ Zip_____

ADDITIONAL INFORMATION

Prescribing Physician_____Phone Number_____

PCP's Name _____Phone Number_____

Are you attending therapy? ☐ No ☐ Yes (If yes, circle all that apply) ◯ Physical Therapy ◯ Occupational Therapy

Therapist's Name_____Phone_____Where:_____

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ADDITIONAL INFORMATION

Is your condition a result of an: ☐ Work accident ☐ Auto accident ☐ Other ☐ N/A

If accident: Date of Injury _____ In Which State did Accident Occur: _____

Adjuster's Name_____ Phone Number _____

Claim number_____ Policy Number_____

Do you have an amputation? ☐ No ☐ Yes Amputation Date_____ Side_____

Cause of Amputation _____

MEDICAL HISTORY

Height _____ Weight _____ General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please circle any of the following conditions you have or have had in the past:

◯Heart Problems	◯Hepatitis A or B	◯Vision Problems	◯Pacemaker/Defibrillator
◯Hypertension	◯Hepatitis C	◯Parkinson Disease	◯Seizure Disorder
◯Vascular Disease	◯HIV Positive	◯Alzheimer Disease	◯Hearing Loss
◯Stroke	◯Rheumatoid Arthritis	◯Psychiatric Problems	◯Currently Pregnant
◯Kidney Disease	◯Osteoarthritis	◯Osteoporosis	◯Pulmonary Disease (TB)

Skin Allergies: _____

List any other conditions that you feel might affect your treatment.

_____

_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I have read and completed all the information on this sheet. I certify this information is true and correct to the best of my knowledge. I will notify Dynamic Orthotic Services, DOS, of any changes in my status or the above information. Should I fail to notify DOS of any changes in the information on this sheet, I agree to accept full responsibility for any and all charges and release DOS from all contractual obligations. I have received the following documents and I agree to the terms listed within them: **DOS Assignment of Benefits, DOS Financial Policy, DOS Notice of Privacy Policy and Medicare Supplier Standards.**

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Relationship to Patient