Dream team PROSTHETICS LLC

Patient Information

Patient Name: (First, MI, Last)_____

Address:_____ Country:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Date of Birth:_____ Social Security Number:_____

Drivers License Number:_____

Gender: ____ M ____ F Marital Status:_____

Emergency Contact Information

Contact Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Physicians Information

Primary Physicians Name:_____

Phone Number:_____

Referring Physicians Name:_____

Phone Number:_____

Employer Information

Current Employer's Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Person:_____ Phone Number:_____

Insurance Information

Are you self pay? ___ Yes ___ No If yes, please skip to **Additional Info.**

Primary

Insurance Company Name:_____

Ins. ID Number:_____ Group Number:_____

Plan Number:_____

Guarantor Name:_____

Relationship to Guarantor:_____ Guarantor DOB:_____

Guarantors Social Security Number:_____

Guarantors Address:_____

City:_____ State:_____ Zip Code:_____

Guarantors Phone Number:_____

Guarantors Employer:_____

Secondary (if applicable)

Insurance Company Name:_____

Ins. ID Number:_____ Group Number:_____

Plan Number:_____

Guarantor Name:_____

Relationship to Guarantor:_____ Guarantor DOB:_____

Guarantors Social Security Number:_____

Guarantors Address:_____

City:_____ State:_____ Zip Code:_____

Guarantors Phone Number:_____

Guarantors Employer:_____

Additional Information

Are you diabetic? _____ Yes ____ No

If **yes**, please provide name & address of physician treating your diabetes:

Physicians Name:_____

Phone Number:_____

Have you received a similar service in the past five years? ___ Yes ___ No

If yes, please explain:_____

Is your amputation work related? ___ Yes ___ No

If yes, please provide your employer at time of accident:

_____

Address:_____

City:_____ State:_____ Zip Code:_____

Contact Person:_____ Phone Number:_____

Claim Number:_____ Date of Accident:_____

Please present your insurance card(s) so we may make copies.

I certify that the information provided by me is true, accurate and complete.

_____ _____

Signature of Patient/Guarantor Date