stridepedorthiccenter
80 Turnpike Drive, Unit 1 • Middlebury, CT 06762 • Tel: 203.758.8307 • Fax: 203.758.8394 • stridepc.com

REGISTRATION FORM

Patient's Name:________________________________ Date of Birth:____________________
Marital Status: M D S W SS#:__________________________
Home Phone:________________ Work Phone:________________ Cell:________________
Street Address:____
City:____ State:_______ Zip:__________
E-Mail Address:___________________________ **For Future Specials/Refurbishment Reminders***
Employer:____
Employer Address:____
Person to contact in case of emergency:__________________________ Phone:__________
(Closest relative not living with you)
Was this due to an accident? Y N Auto_______ Work_________ Other___________
Where were you injured?____________________________ Date of Injury:_______________
Do you have an attorney representing you? Y N Name:____________________________
Attorney Address:____
Primary Insurance Co:_____________________________ ID:_________________________
Group:__________________ Subscriber:__________________ Date of Birth:_____________
Employer:_________________________ Occupation:______________________________
Secondary Insurance Co:_____________________________ ID:______________________
Group:__________________ Subscriber:__________________ Date of Birth:_____________
Employer:_________________________ Occupation:______________________________
Height:__________ **Weight:**__________ **Shoe Size:**__________ **Shoe Style:**__________
Primary Care Physician:__________________________________ Phone:______________
Referring Physician:_____________________________________ Phone:______________
Allergies:____
Current Medications:____
Check Conditions that apply to you:
Heart Disease____ Respiratory____ Diabetes____ Seizure____ Stroke____ Cancer____
Skin _____ Other (please explain) ____
Smoker Y N Surgery:__________________________ Date:_______ Reason:___________
____

BILLING INFORMATION (please complete this section only if bills are to be sent to someone other than the person described above - otherwise write "same")
Name of person to bill:____
Address:____
Home Phone:________________ Work Phone:________________ Cell:________________
Relationship to patient:____

FINANCIAL DISCLOSURE/PATIENT SIGNATURE

I have been informed at this time that my pedorthic device, which has been prescribed to me by my physician, may not be covered by insurance. I understand that any remaining balance is my responsibility. I hereby assign all medical benefits to be paid directly to Stride PT & Pedorthic Center. I authorize disclosure of my records to my insurance carrier, lawyer and referring doctor. I also release any medical information necessary to process my claim. I do hereby agree and give my consent for Stride PT & Pedorthic Center to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and mental condition.

Patient or Parent/Guardian Signature:___________________________ Date:______________

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Biomechanical Medical History Form

Your answers to the following questions will help us understand your medical history as it pertains to your pedorthic care. Please fill out as much of this questionnaire as possible.

Patient Name: ______________________________ DOB: ______________

In your own words, please BRIEFLY describe the condition you have been referred to Stride for today:

____

____

____

____

Please check and respond to indicate if you have ever had the following conditions:

☐ Heart Disease or Heart Attack ☐ Stroke ☐ High Blood Pressure ☐ Asthma ☐ Hepatitis C

☐ HIV ☐ Shingles ☐ Latex Allergies ☐ Osteoporosis ☐ Seizures

☐ Diabetes (Type I or Type II). Medications: ______________________

☐ Fractures of the lower limbs: Yes No

☐ Sprains of the lower limbs: Yes No

☐ Surgeries to the Spine or lower limbs: Yes No

Note: Your attending practitioner will review the details of your medical history with you during your examination.

Pain:

Patient/Guardian Signature ______________________________ Date: ________

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Date: ______________________

I HAVE RECEIVED INFORMATION FROM STRIDE PEDORTHIC CENTER ABOUT HIPAA PRIVACY PRACTICES AND MEDICARE DMEPOS SUPPLIER STANDARDS WHERE APPLICAPABLE.

Patient Name: ____

Patient Signature: ____

(Guardian if Minor)