



# stride pedorthic center

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## 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: \_\_\_\_\_

## 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:**

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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 III). Medications: \_\_\_\_\_

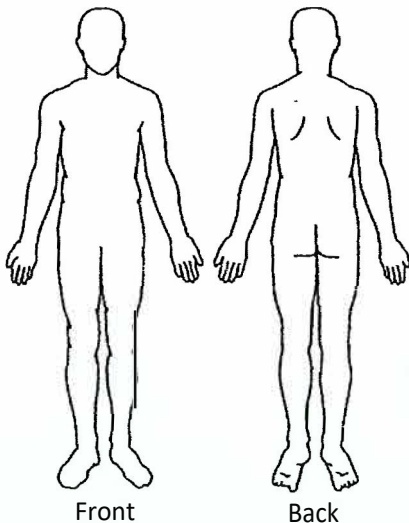
Fractures of the lower limbs: Yes No





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:



-  Ache
-  Shooting
-  Pins & needles
-  Sharp pain

Please mark the type and location of your pain on these pictures

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

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)