Leimkuehler inc.
PROSTHETICS & ORTHOTICS

PATIENT NAME _____

Address_____ City_____ Zip Code _____

Home Phone Number_____ Work _____ Cell Phone _____

Email_____(for an online survey upon delivery)

Preferred Method of Contact: home phone, work phone, cell phone or email (please circle)

Date of Birth_____ Social Security Number_____

Sex_____ Martial Status_____Employer_____

Emergency Contact_____
Name Phone Relationship

Primary Care Physician_____ Diabetic Physician_____

PRIMARY INSURANCE_____

If MEDICARE, have you signed with another insurance offering Medicare coverage

Policy Number_____ Group Number_____

Insured Name_____ Birth_____ Relationship to Insured_____

Secondary Insurance_____

Policy Number_____ Group Number_____

Insured Name_____ Birth_____ Relationship to Insured_____

Is This Covered by **WORKER'S COMPENSATION** (Yes/No) Claim Number_____

Date of Injury_____ Employer_____ Address_____

Person Responsible for Bill _____

Address_____

Phone Number_____ Social Security Number _____

Employer_____ Work Phone_____

Divorced Parents: The parent accompanying the child for treatment will be held responsible for all bills.

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

Patient's Signature X_____

Responsible Party X_____
(Guardian, if Minor)

How did you hear about us? referred by MD/PT, friend, internet, other:_____