

Welcome to Prosthetic Illusions Inc

(aka Rocky Mountain Anaplastology Inc)

Date _____

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____ Sex M F

Address _____ City _____ State _____ Zip _____

H/Phone _____ W/Phone _____ Cell _____ Email _____

SSN# _____ Date of Birth _____ Marital Status: married single divorced widowed

Occupation _____ Employer _____ Veteran YES NO

Emergency Contact Person _____ Phone _____

Whom should we thank for this referral ? _____

INSURANCE INFORMATION

Patient relationship to insured: Self Spouse Child Other _____
(skip this next section if information is the same as above)

First Name _____ MI _____ Last Name _____ Sex M F

Address _____ City _____ State _____ Zip _____

H/Phone _____ W/Phone _____ Cell _____ Email _____

SSN# _____ Date of Birth _____ Marital Status: married single divorced widowed

* * *

Is this workman's comp? YES NO Occupation _____ Employer _____

Primary Insurance _____ ID# _____ GROUP# _____

Secondary Insurance _____ ID# _____ GROUP# _____

PHYSICIAN INFORMATION

Primary Care Physician _____ Phone # _____

Referring Physician _____ Phone # _____

MEDICAL NEED / HISTORY

Reason for visit: _____ Date of last surgery related to current condition? _____

When and where was your previous prosthesis made? _____

Are you allergic to nuts? YES NO Are you allergic to onions? YES NO Other allergies? _____

Are you currently undergoing treatment or taking medication that could affect the work done in this office (diabetes, HIV, chemo, etc.)? Please describe _____

Permission to contact the patient in the following manner (check all that apply):

Okay to leave a message on the home phone: YES NO

Okay to leave a message on the work phone: YES NO

Okay to call and remind of appointment with date & time: YES NO

Okay to mail written communication to the above address: YES NO