Welcome to Prosthetic Illusions
(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 Are you a smoker? YES NO

Other allergies?_____

If you are 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
Okay to contact regarding insurance updates:	YES	NO