ALLIANCE ORTHOPEDIC LABS, INC.

keeping life in motion

PATIENT INTAKE FORM

Patient Name: _____ Today's Date: _____

Date of Birth: ____/____/____ Gender: ____ Email Address: _____

Home Phone: _____ Work: _____ Other: _____

Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Prescription: _____ Diagnosis: _____

Referring Doctor: _____ Phone: _____

Physical Therapist: _____ Facility/School: _____

Have you had any type of orthotic device in the past? Yes: _____ No: _____

If yes, what type? _____

Primary Insurance: _____ ID#: _____

Policy Holder: _____ Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____

Policy Holder: _____ Relationship to Patient: _____

If no insurance, please identify the person financially responsible:

_____ Relationship to Patient: _____

Policy Holder/Responsible Person's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Other: _____

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