

Patient Intake Form

Patient Name:			Date:
Sex:	Birthdate:	Phone:	SSN:
Address:			
City:		State:	Zip Code:
Height:	Weight:	Email Address:	
Spouse/Legal Guardian:			Phone:
Emergency Contact:			Phone:
Is the patient currently living in a skilled nursing facility? If yes, please list facility.			
Is the patient currently receiving home health / hospice care? If yes, please list agency.			
Primary Insurance:			Policy Number:
Group Number:		Insured Name:	
Secondary Insurance:			Policy Number:
Group Number:		Insured Name:	
Surgeon:			Phone:
Primary Physician:			Phone:
Date of Injury:	Date of Amputation:	Hospital:	
Workers' Compensation Agency (if applicable):			Claim Number:
Adjustor:			Phone:
Case Worker:			Phone:
Have you ever received this type of product within the last 5 years? If yes, please list provider.			

Level of Amputation

- | | | |
|---|--|---|
| <input type="checkbox"/> Right: Upper Extremity | <input type="checkbox"/> Right: Above Knee | <input type="checkbox"/> Left: Above Knee |
| <input type="checkbox"/> Left: Upper Extremity | <input type="checkbox"/> Right: Below Knee | <input type="checkbox"/> Left: Below Knee |
| <input type="checkbox"/> Partial Foot | <input type="checkbox"/> Other: _____ | |

Please check the appropriate box for the primary reason for your amputation:

Trauma

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Automobile Crash | <input type="checkbox"/> Work Related Injury | <input type="checkbox"/> Burn |
| <input type="checkbox"/> Motorcycle Crash | <input type="checkbox"/> Fire Arm Injury | <input type="checkbox"/> Spider Bite |
| <input type="checkbox"/> Pedestrian Accident | <input type="checkbox"/> Machine/Farm Injury | <input type="checkbox"/> Frostbite |
| <input type="checkbox"/> Other: _____ | | |

Disease

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Non-healing Wound | <input type="checkbox"/> Blood Clot |
| <input type="checkbox"/> Gangrene | <input type="checkbox"/> PAD | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congential Limb Deficiency | | |
| <input type="checkbox"/> Other: _____ | | |

How did you hear about Fourroux Prosthetics?

- Physician
- Friend
- Television
- Magazine
- Internet
- Other: _____