FOURROUX PROSTHETICS

*Building Relationships for Life*

# 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. | | | |

FOURROUX PROSTHETICS

*Building Relationships for Life*

**Patient Etiology**

Level of Amputation

- ☐ Right: Upper Extremity
- ☐ Left: Upper Extremity
- ☐ Partial Foot
- ☐ Right: Above Knee
- ☐ Right: Below Knee
- ☐ Other: _____
- ☐ Left: Above Knee
- ☐ Left: Below Knee

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

Trauma

- ☐ Automobile Crash
- ☐ Motorcycle Crash
- ☐ Pedestrian Accident
- ☐ Other: _____
- ☐ Work Related Injury
- ☐ Fire Arm Injury
- ☐ Machine/Farm Injury
- ☐ Burn
- ☐ Spider Bite
- ☐ Frostbite

Disease

- ☐ Diabetes
- ☐ Gangrene
- ☐ Congential Limb Deficiency
- ☐ Other: _____
- ☐ Non-healing Wound
- ☐ PAD
- ☐ Blood Clot
- ☐ Cancer

How did you hear about Fourroux Prosthetics? (choose all that apply)

- ☐ Physician
- ☐ Friend
- ☐ Televison
- ☐ Magazine
- ☐ Internet
- ☐ Other: _____