Brownfield's
PROSTHETICS & ORTHOTICS restoring independence | renewing lives
Meridian Nampa T | 208.342.4659 F | 208.342.8211 www.brownfieldstech.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: _____ SSN (last 4 for Veterans): _____

Address: _____

City/State/Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email Address: _____ Marital Status: _____

Please circle your preferred method of contact: ☐ Home ph ☐ Work ph ☐ Cell ph ☐ Email

Occupation: ☐ Employed ☐ Student ☐ Retired ☐ On Disability ☐ Child ☐ Other: _____

The name(s) listed below are family or friends to whom I wish to grant limited verbal discussion concerning my health care and/or billing information, as they deem necessary. This consent will be my responsibility to update, as I recognize that relationships and friendships change over time.

Name: _____ Relationship:_____ Phone:_____
Name: _____ Relationship:_____ Phone:_____

Referring Physician (Doctor who signed your prescription): _____

Primary Care Physician: ***(first and last name)***_____

Is your injury the result of an auto accident? NO YES Workers Comp? NO YES

Are you diabetic? NO YES (Type I) YES (Type II)
Who is the doctor who treats your diabetes? _____

Have you had the same or a similar item/equipment in the past? NO YES
When and where did you get the item? _____

RESPONSIBLE PARTY (PARENT OR GUARDIAN) IF MINOR CHILD

Name: _____ Phone: _____
Address: _____ Relationship: _____

IS PATIENT CURRENTLY RESIDING IN A SKILLED NURSING FACILITY?

Circle one: NO YES

If yes, name of facility: _____ Date Admitted: _____

Please complete backside

INSURANCE INFORMATION

A copy of your insurance cards is required (Veterans may skip this section)

Primary Insurance: (***please fill out ins name***)_____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Relationship to Patient:_____
Policy Holder's Employer: _____

Secondary Insurance: (***please fill out ins name***)_____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Relationship to Patient:_____
Policy Holder's Employer: _____

WORKER'S COMPENSATION INFORMATION (If applicable)

Worker's Comp Insurance Carrier: _____
Claim No. _____ Date of Injury: _____
Insurance Contact: _____ Phone: _____

Although Brownfield's will bill your insurance company, the final balance is your responsibility and is due within 90 days of delivery. For custom products NOT covered by insurance, Brownfield's requests a 50 percent down payment before placing an order or beginning manufacture.

ALL CUSTOM ITEMS ARE NON-REFUNDABLE.

I HEREBY AUTHORIZE Brownfield's Prosthetic & Orthotic Technologies to bill my payer of medical benefits for services which I have received and assign payment for those services to Brownfield's. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I also authorize Brownfield's to release to the payer of medical benefits, or any of its agents, any medical or other information needed to determine payment of these benefits or benefits for related services. I certify that the information I provided is true and correct to the best of my knowledge. I will notify Brownfield's of any change to the above information. I understand that by disclosing my email address, Brownfield's employees may contact me with protected health information, and I assume responsibility for such.

SIGNATURE _____ **DATE** _____