Brownfield's
PROSTHETICS & ORTHOTICS restoring independence | renewing lives
Meridian Nampa

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: _____ SSN: _____

Email Address: _____ Marital Status: _____

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

Address: _____

City/State/Zip: _____

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

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

Emergency Contact Name: _____ Phone Number_____

Relationship to Patient: _____

RESPONSIBLE PARTY (PARENT OR GUARDIAN) IF MINOR CHILD

Name: _____ Phone: _____

Address: _____ Relationship: _____

Referring Physician (Doctor who signed your prescription): _____

Primary Care Physician: _____

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

Are you diabetic? Yes No If Yes, which type: Type 1 Type 2

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? _____

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: _____
Insured's Name: _____
Insured's Date of Birth: _____
Insured's employer: _____

Secondary Insurance: _____
Insured's Name: _____
Insured's Date of Birth: _____
Insured'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** _____