IAM O&P, Inc.
Orthotic & Prosthetic Services

PATIENT INFORMATION FORM

NAME: _____
(Last) *(First)*

DATE OF BIRTH: ____/____/_____ SOC.SEC.#: _____ MALE / FEMALE

ADDRESS: _____
(Street Address)

_____
(City) *(State)* *(Zip)*

PHONE: _____ **ALT** #: _____

PRIMARY CONTACT: _____ RELATIONSHIP: _____

EMAIL ADDRESS: _____

PRIMARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER (If different from patient): _____ D.O.B.: _____

INSURANCE ADDRESS: _____

_____ PHONE: _____

NOTES *(Co-pay/Co-Ins, Deductibles, Max benefits etc.)*: _____

SECONDARY INSURANCE: _____POLICY #: _____

SUBSCRIBER (If different from patient): _____ D.O.B.: _____

INSURANCE ADDRESS: _____

_____ PHONE: _____

NOTES *(Co-pay/Co-Ins, Deductibles, Max benefits etc.)*: _____

FACILITY/LOCATION OF CARE: _____

PHYSICIAN NAME: _____ NPI: _____

PRIMARY DIAGNOSIS: _____ ICD9: _____

SECONDARY DIAGNOSIS: _____ ICD9: _____

OTHOSIS ORDERED: _____

ANY OTHER NECESSARY INFORMATION NEEDED? _____

_____

PATIENT INFORMATION LAST VERIFIED/UPDATED: ___/___/___ ___/___/___ ___/___/___
(please document date when you last verified information, complete new form annually or as needed)