Patient Intake Form

Contact Information						
Patient Name:	First Last				Date of Birth:	
Male / Female	Height:		Weight:		SSN:	
Street Address:						
City/State/ZIP:						
Phone Number:	Home Mobile Work			Home Mobile Work		

Additional Information		
Emergency Contact Info	Name Phone Number Relation	
Marital Status:	Minor Single Married Divorced Separated Widowed	
Employment Status:	☐ On Disability ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Self-Employed ☐ Unemployed	Employer Name (if applicable): Work Phone Number
Who referred you?	Name: _____ Phone #:_(__)_____-_____	
Who wrote your prescription?	Name: _____ Phone #: (___)_____-_____ Location: _____	Do you have a latex allergy? Yes No

Insurance Information				
Primary Insurance	Company:		ID:	
	Subscriber:		Group:	
Secondary Insurance	Company:		ID:	
	Subscriber:		Group:	

Shoe/Insert Information (if applicable)				
Are you diabetic? If yes, please specify if you are Type I or II	Yes No	Type I Type II	Is there an MD or DO who you see for diabetes?	
			Doctor's Name:	
			Location:	
			Last seen:	