

# Horton's Orthotic Lab, Inc.

## **Patient Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ Apt #: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_ Diabetic Doctor: \_\_\_\_\_

**Have you ever worn any type of brace? 9 Yes 9 No. If Yes what type and when?** \_\_\_\_\_

**Would you like to request a restriction of medical information? 9 Yes 9 No**

## **Fathers Information:** (Complete ONLY if patient under the age of 18)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt #: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

## **Mothers Information:** (Complete ONLY if patient under the age of 18)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt #: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

## **Nearest Relative Not Living With The Patient:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## **Insurance Information:**

**Circle One:**      Self Pay      Group Insurance      Workers Comp      Medicaid      Medicare  
Policy or ID# : \_\_\_\_\_ Group: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

