

Date _____



Your Westcoast Brace & Limb team is here to support you. Please complete the following information completely and accurately, so that we can provide you with the finest care and most favorable results. Thank you!

Patient (Legal) Name First _____ Middle Initial _____ Last _____

Social Security # _____ - _____ - _____ DOB _____ - _____ - _____ Male Female

Single Married Other Phone _____ Work _____ Cell _____

By checking this box, you authorize Westcoast Brace & Limb to leave detailed phone messages for you, which may include private healthcare information.

Email _____ @ _____

Street Address _____ City _____ State _____ Zip _____

By checking this box, you authorize Westcoast Brace & Limb to utilize email as a form of communication with you. Our communications only include information regarding your treatment plan, updates, and our services. Your social security number **will never** be included in an email communicate from us.

EMERGENCY CONTACT Full Name _____ Phone _____

RESPONSIBLE PARTY (Check one): The responsible party is listed above Is **different** than above:

Full Name _____ Relationship: Self Spouse Dependent Other

Social Security _____ - _____ - _____ DOB _____ - _____ - _____

Phone _____ Work _____ Address _____

How did you hear about Westcoast Brace & Limb? (Check all that apply)

Medical Professional Hospital Visit Insurance Internet Print Ad (Which one): _____

Television Another WCBL Patient Military Base/MAFB WCBL Mailer/Postcard Westcoast Wire Newsletter

Special Event (Event description): _____ Other (please explain): _____

Insurance Information

Please provide our receptionist with a copy of your photo ID, all insurance cards, and any prescriptions that you have.

Primary Insurance _____ Policy ID _____ Group _____

If the policy holder is someone other than the patient: Relationship: Spouse Dependent Not related

Policy Holder Name _____ DOB ____ - ____ - ____ Social Security ____ - ____ - ____

Secondary Insurance _____ Policy ID _____ Group _____

If the policy holder is someone other than the patient: Relationship: Spouse Dependent Not related

Policy Holder Name _____ DOB ____ - ____ - ____ Social Security ____ - ____ - ____

Work Comp

Please check here if your injury is a workers' compensation injury and please complete the section below.

Employer Name (at time of injury) _____ Phone _____

Address _____ Date of Injury ____ - ____ - ____ State Where Injury Occurred _____

Insurance Carrier Name _____ Claim # _____

Claims Adjuster _____ Phone _____

Nurse Case Manager _____ Phone _____

Auto Accident/Third Party Liability

Please check here if your injury was due to an auto accident

Please check here if your injury was due to third party liability (someone else is liable for your injury)

Please check here if you have an attorney Attorney Name _____ Phone _____

Please check here if you have filed a lawsuit related to your injury

Other Medical Professionals Involved in Your Care

Please tell us about the other medical professionals involved in your care. Who referred you to us? Please check the referring party.

Primary Care Physician _____ Phone _____

Surgeon _____ Phone _____

Physical/Occupational Therapist _____ Phone _____

Other: _____ Phone _____

Authorization to Release Protected Health Information

I _____ give permission to Westcoast Brace & Limb to release any information, verbally or written, on my behalf to the following persons:

Please note that in order for Westcoast Brace & Limb to communicate to anyone other than the patient/guardian, that individual's name must be listed below.



Name _____


Phone _____ Relationship to Patient _____

Name _____

Phone _____ Relationship to Patient _____

Clinical Photograph Release

I understand that Westcoast Brace & Limb may obtain a photograph of me for clinical purposes. This photograph of me will remain in my records and may be forwarded to my treating medical professional(s) (physician, nurse, therapist, etc...) for clinical purposes.

 Patient/Guardian Signature _____ Date _____

Patient Questionnaire

Sometimes when we are speaking with your physicians or your insurance company, we are asked questions about your visit and your condition. The following questions help us to have the right answers. Thank you for taking a moment to complete this brief questionnaire.

Please tell us why you have come to Westcoast Brace & Limb today (injury detail, condition, symptoms, circumstances, etc...)

Is your injury, condition, or symptom due to any of the following? (Please check one)

Disease, please describe: _____ Congenital Trauma/Injury, please describe _____

If trauma/injury: Date of injury _____ - _____ - _____

Where did the trauma/injury occur? _____

Unknown/Other (Please describe): _____

When did your injury, condition, or symptom begin? _____

Has this injury, condition, or symptom occurred more than once? No Yes If yes, please explain: _____

If this injury has occurred more than once, how were you treated? (Please check all that apply)

Therapy Surgery Medication Other: _____

Additional Information (Optional): _____

Have you ever used a brace and/or an artificial limb before? (Please check one): No Yes

If yes, please answer the questions below as completely and accurately as you are able:

What type of brace or artificial limb did you receive? _____

When did you receive your most recent brace or artificial limb? (Month/Year): _____ - _____

What was the name of the physician who prescribed this device? _____

Who provided this device to you? (Orthotic/Prosthetic Facility) _____

What did you like about the device you received? _____

What did you dislike about the device you received? _____

Other Health Conditions (Please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Obesity | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Type 1 Diabetes | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Type 2 Diabetes | <input type="checkbox"/> Post-Polio |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Wound Heal Delay | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Previous Heart Attack | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Depression | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Previous Surgery: _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Memory Loss | |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Cancer | |

Personal Background

Living Situation (please check all that apply)

I live alone I live with someone else I am a caregiver I have a caregiver in my home

Children Living at Home (if any) _____ If so, ages _____

Is your home adequately accessible for you? Yes No

If no, please explain: _____


Occupation _____ Employer Name _____

Physical requirements for work _____

Your Goals (Related to orthotic and/or prosthetic care):

Verification of Information Accuracy

I verify that, to the best of my knowledge, the information I have provided in this 4 page form is accurate.

 Patient/Guardian Signature _____ Date _____