# BLUEGRASS BRACING
# PATIENT INFORMATION SHEET – BONE STIMULATOR

Revised 5/4/15

## PATIENT INFORMATION

Full Name: ______________________ Date of Birth: ______________ Sex: ☐ M ☐ F

Address: ______________________ Soc. Sec. #: ______________ Ht: _____ Wt: _____

City State Zip ______________________ Home Phone: ______________________

Employer: ______________________ Cell Phone: ______________________

Employer Phone: ______________________ Email: ______________________

Description of Accident or Injury / Past Medical History: ______________________

______________________

______________________

______________________

## EMERGENCY CONTACT

Name: ______________ Relation: __________ Phone Numbers: ______________________

Name: ______________ Relation: __________ Phone Numbers: ______________________

## INSURED OR PERSON RESPONSIBLE FOR BILL (RELATION TO PATIENT: ☐SPOUSE ☐ PARENT ☐ CHILD ☐OTHER)

Name/Relation: ______________________ Phone Number: ______________________

Address: ______________________ Soc. Sec. #: ______________________

City State Zip: ______________________ Date of Birth: ______________ Sex ☐ M ☐ F

Employer: ______________________ Employer Phone: ______________________

## INSURANCE #1 ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Work-Comp ☐ Auto ☐ Date of Injury or Accident __________

Carrier: ______________________ Carrier Phone: ______________________

Carrier Address: ______________________ City State Zip: ______________________

ID/Claim Number: ______________________ Case Manager: ______________________

Group Name: ______________________ Group Number: ______________________

## INSURANCE #2 ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Work-Comp ☐ Auto ☐ Date of Injury or Accident __________

Carrier: ______________________ Carrier Phone: ______________________

Carrier Address: ______________________ City State Zip: ______________________

ID/Claim Number: ______________________ Case Manager: ______________________

Group Name: ______________________ Group Number: ______________________

## PHYSICIAN'S PRESCRIPTION / VERBAL ORDER

Physician: ______________________ Practice Name: ______________________

Person Who Called in the Verbal Order: ______________ Date and Time: ______________________

Bone Stimulator Model #: ______________________ Bone Stimulator Serial #: ______________________

Where Did You Fit The Patient With The Bone Stimulator: ______________________

______________________

______________________

When Did You Fit The Patient: ______________________ Practitioner Filling Out Form: ______________________