BLUEGRASS BRACING
PATIENT INFORMATION SHEET - BRACING

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: _____ CellPhone: _____

Employer Phone: _____ Email: _____

Description of Accident or Injury / Past Medical History: _____

_____

_____

_____

EMERGENCY CONTACTS

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 / IN-PATIENT OR OUT-PATIENT STATUS

Prescribing Physician's Name: _____ Hospital and Room Number: _____

Person Who Called in the Verbal Order: _____ Date and Time: _____

Diagnosis Codes: _____

Description of Brace: ☐ Custom ☐ Prefab _____ Size _____

Modifications to Pre-Fab Brace: _____

Do We Need a Hospital P.O. For This Brace: _____ Why: _____

_____

_____

Is Brace for In-Patient Rehab Use: _____ When is Patient Being Discharged: _____

Where is Patient Going after Discharge: _____ Practitioner Filling out Form: _____