BLUEGRASS PEDIATRIC BRACING
PATIENT INFORMATION SHEET

REVISED 2-2016

PATIENT INFORMATION:

First Name: ____________________ Middle:____________Last_______________________________ Today's Date______________

Date of Birth: _______________________ Sex: ☐ M ☐ F Parent's name(s) ____

Address: ____ Soc. Sec. #: ____________________________ Ht: _____ Wt: _____

City State Zip ____ Preferred Phone: ____

Patient Diagnosis:____ **Please circle**: Right Side Left Side Both Spine

When did this condition occur? Please circle one: At Birth or Date of injury_________________________________

Please describe patient history:____

____

____

EMERGENCY CONTACTS:

Name:____________________________ Relation:______________________ Phone Number:____________________________________

Name: ____________________________Relation: _____________________ Phone Number:____________________________________

Email Address:____

INSURED OR PERSON RESPONSIBLE FOR BILL (RELATION TO PATIENT: ☐ PARENT ☐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: ____

BLUEGRASS PEDIATRIC BRACING
PATIENT HISTORY SHEET
rev 2-2016

Patient Name__________________________ **DOB**________________ **AGE**____________ **Today's Date**___________

This form filled out by ____________________________________ **Relation to patient**_____________________________

Who referred you to Bluegrass Pediatric Bracing- Doctor Physical Therapist Friend Other: _______________________

Do you have a Bracing Prescription?__________________ From Dr.:____

Has patient ever had orthotics/bracing before? Please list____

Does your child have bracing right now?______________ When did you receive it? ____________________________

How is it working?____

____

School attended______________________________ Physical Therapist at School name______________________________

PEDIATRICIAN NAME: DR.________________________________ Office Phone #__________________________________

Please list other Specialist Doctors or Physical Therapists involved in your child's care:

ORTHOPEDIC DR.___________________________ LOCATION___________________ PHONE_____________________

NEUROLOGIST/PHYSIATRIST _________________________LOCATION___________ PHONE____________________

OUTPATIENT THERAPIST_______________________ LOCATION___________________ PHONE_________________

OTHER ____ PHONE______________________________

HAS YOUR CHILD:

Ever had Orthopedic Surgery? Please explain____

Ever received Botox or Serial Casting? Please explain____

____

What do you hope new bracing will do for your child?____

____

What concerns do you have about bracing?____

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