Cotton Orthotic and Prosthetic Associates
Patient Information Form

Patient Name:_____ Date of Birth:_____
First Name MI Last Name

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Social Security #:_____

Spouse/Parent/ or Guardian (if applicable):_____ Phone:_____

Emergency Contact:_____ Phone:_____

Employer:_____ Work Phone:_____

How did you hear about us?_____ Do you reside in a nursing facility?_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Are you Diabetic? ☐ Yes ☐ No Diabetic Physician:_____ Phone:_____

Referring Physician's Name:_____ Phone:_____

Diagnosis:_____ Date of Injury:_____

Is the Injury Related to: ☐ Auto ☐ Work ☐ Accident ☐ Other ☐ Not Applicable

Employer at the time of Injury:_____ Phone:_____

Workman's Compensation Insurance Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Claim Number:_____ Adjuster:_____

Have you had a prosthesis or brace made in the past 5 years? ☐ Yes ☐ No From which company?_____

Primary Insurance:_____ Policy Number:_____ Phone:_____

Group Name/Number:_____ Name of Insured:_____ DOB:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent

Secondary Insurance:_____ Policy Number:_____ Phone:_____

Group Name/Number:_____ Name of Insured:_____ DOB:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent

Please present your INSURANCE CARD to the front desk

I certify that the information provided by me on this form is true, accurate, and complete.

Signature of Patient:_____ Date:_____

Signature of Responsible Party:_____ Date:_____

Relationship to Patient:_____