United Prosthetics & Orthotics®

We Get You Back to Living

Patient Intake Form

Patient Name:			Date:
Sex:	Birthdate:	Phone:	SSN:
Address:			
City:		State:	Zip Code:
Height:	Weight:	Email Address:	
Spouse/Legal Guardian:			Phone:
Emergency Contact:			Phone:
Is the patient currently living in a skilled nursing facility? If yes, please list facility.			
Is the patient currently receiving home health / hospice care? If yes, please list agency.			
Primary Insurance:			Policy Number:
Group Number:		Insured Name:	
Secondary Insurance:			Policy Number:
Group Number:		Insured Name:	
Surgeon:			Phone:
Primary Physician:			Phone:
Date of Injury:	Date of Amputation:		Hospital:
Workers' Compensation Agency (if applicable):			Claim Number:
Adjustor:			Phone:
Case Worker:			Phone:
Have you ever received this type of product within the last 5 years? If yes, please list provider.			

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Patient Etiology

Level of Amputation

- ☐ Right: Upper Extremity
- ☐ Left: Upper Extremity
- ☐ Partial Foot
- ☐ Right: Above Knee
- ☐ Right: Below Knee
- ☐ Other: _____
- ☐ Left: Above Knee
- ☐ Left: Below Knee

Please check the appropriate box for the primary reason for your amputation:

Trauma

- ☐ Automobile Crash
- ☐ Motorcycle Crash
- ☐ Pedestrian Accident
- ☐ Other: _____
- ☐ Work Related Injury
- ☐ Fire Arm Injury
- ☐ Machine/Farm Injury
- ☐ Burn
- ☐ Spider Bite
- ☐ Frostbite

Disease

- ☐ Diabetes
- ☐ Gangrene
- ☐ Congential Limb Deficiency
- ☐ Other: _____
- ☐ Non-healing Wound
- ☐ PAD
- ☐ Blood Clot
- ☐ Cancer

How did you hear about United Prosthetics & Orthotics? (choose all that apply)

- ☐ Physician
- ☐ Friend
- ☐ Televison
- ☐ Billboard
- ☐ Social Media
- ☐ Other: _____