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REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	❑ Miss ❑ Ms. ❑ Mrs. ❑ Mr.

Birth date:	Age:	Sex: M F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	Home phone no.:	Cell phone no. :
City:	State:	Postal Code:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr. Name:	❑ Hospital Name:	❑ Other

Pharmacare no.	Family Physician:	Phone:

Extended Health Benefits: (Please circle) Yes No	Name of Extended Health Company:

Other: (DVA, WCB, ICBC)

MEDICAL INFORMATION

Date of Amputation:		Cause of Amputation:	
Weight:	Shoe Size:	Affected Side: L R	Level of Amputation: AK BK
Previous Prosthetic Supplier:		Date when last prosthesis was supplied:	

Comments:

FAMILY MEMBER OR FRIEND CONTACT INFORMATION

Name of relative or friend	Relationship to patient	Home phone no.	Work phone no.
		( )	( )

The above information is true to the best of my knowledge. I authorize my Pharmacare benefits to be paid directly to Orthomed Technology Inc. I understand that I am financially responsible for any balance. I also authorize Orthomed Technology Inc. to release any information required to process my claims.

Patient/Guardian signature	*Date*