



Equipment /Orthotics	Name of Vendor and Address	Phone Number

**Immunization Status:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Care Providers (Not Physicians)	Service Provided	Location & Phone Number

**Hospital Preference:** \_\_\_\_\_

**Insurance Information:** (Always take insurance card to appointments with you)

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contact Information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Functional Status:** (Do you live alone, need assistance for specific activities, drive, volunteer, work) \_\_\_\_\_

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