SCOTT SABOLICH
PROSTHETICS & RESEARCH

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Oklahoma City, OK 73114
Phone: 405.841.6800

Dallas, Texas
15900 North Preston Road
Dallas, TX 75248
Phone: 214.382.9270

www.scottsabolich.com

Patient Information

Name_____ Nickname_____
First Middle Last

Date of Birth_____/_____/_____ Social Security Number_____-_____-_____Gender ☐ Male ☐ Female

Email_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employed ☐ Yes ☐ No Language ☐ English ☐ Spanish ☐ French ☐ Other

Home Phone_____Cell Phone_____Work Phone_____

Home Address_____City_____State_____Zip_____

Mailing Address_____City_____State_____Zip_____
(If different than home address)

Cause of Amputation_____Date_____

Level of Amputation ☐ Left ☐ Right ☐ Bilateral
☐ Above Knee ☐ Below Knee ☐ Partial Foot
☐ Above Elbow ☐ Below Elbow ☐ Other_____

Where was your last prosthesis made_____Date_____

Referring Physician_____Phone_____

Primary Care Physician_____Phone_____

Spouse/Caregiver Information

Name_____ Relationship_____

Home Phone_____Cell Phone_____Work Phone_____

Emergency Contact (*Name of Closest Relative Not Living With You)*

Name_____ Relationship_____

Home Phone_____Cell Phone_____Work Phone_____

Insurance Information

Primary Insurance	Secondary Insurance
Provider_____	Provider_____
ID #_____	ID #_____
Group #_____	Group #_____
Responsible Party/Guarantor Information:	**Responsible Party/Guarantor Information:**
Name of Insured_____	Name of Insured_____
Relation to Insured_____	Relation to Insured_____
SSN _____ DOB_____	SSN _____ DOB_____
Address _____	Address _____
City_____State_____Zip_____	City_____State_____Zip_____
Phone	Phone

Disclosure of Information

I understand that my medical records and billing information are made and retained by Sabolich and are accessible to Sabolich personnel who may use and disclose medical information for Sabolich's operations and functions and to any other health care personnel involved in my continuum of care for this admission. During my visits to Sabolich, I will come in contact with other Sabolich patients who may be encouraged by my progress and whose progress may be encouraging to me. I do ____ do not ____ agree to the exchange of a limited amount of information about my case to be used to encourage others.

_____ _____

Patient (or Parent/Guardian) Name (Printed) Date Patient (or Parent/Guardian) Signature Date

_____ _____

Patient Representative (Printed) Date Patient Representative Signature Date

How Did You Hear About Us

☐ Primary Care Physician ☐ Nurse ☐ Friend

☐ Surgeon ☐ Physical Therapist ☐ Advertising

☐ Hospital ☐ Case Manager ☐ Newspaper

☐ Other _____

All of the information I have provided is true and correct.

_____ _____

Patient (or Parent/Guardian) Name (Printed) Date Patient (or Parent/Guardian) Signature Date

_____ _____

Patient Representative (Printed) Date Patient Representative Signature Date