



Mr. Mrs. Ms. Miss

Patient Name _____
 Last Name First Name M.I.

Date of Birth _____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Alternate Phone # (____) _____

Marital Status: Single Married Divorced Widowed Other

Email Address _____

Employer _____ Employer's Phone # (____) _____

Employer's Address (Street, City, State, Zip) _____

Spouse/Parent/Guardian (Circle one) _____ Home Phone # (____) _____

Referral Source _____ Primary Care Physician _____ Medical Group _____

How did you hear about Multi Sports Orthotics? Physician Physical Therapist Sports Event
 Other _____

Diagnosis/Nature of Injury _____ Date of Onset _____

Is Injury Related to: Work Auto Other Accident Non-Accident

FINANCIAL POLICY

I agree to the following:

I agree that I am committed to paying for services rendered at my initial evaluation.

I agree to be fitted with my orthotics within seven days after I have been notified of their completion.

Payment must be made in full when evaluated and casted for the custom molded orthotics.

All orthotics have a 30-day warranty on adjustments and repairs.

No returns on custom molded products.

A service charge of \$25.00 will be applied to all returned checks.

I agree that Multi Sport Orthotics requires a 24 hour notice for cancellation of scheduled appointments and I will be financially responsible for late cancellations and missed appointments (no shows). The cancellation fee is \$100.00.

 Patient (or Parent/ Guardian) Date

 Representative (If patient is unable to sign) Relationship to Patient