# Brace Intake Form

**Patient Name (Last, First & MI) _____ Date of Birth _____**

**Address: _____ City: _____**

**State: _____ Zip: _____ Phone Number: _____ Cell: _____**

**Email Address Required: _____Male ☐ Female ☐Height _____ Weight _____**

**Emergency Contact _____ Relationship _____Phone Number: _____**
**(*that does not live with patient)***

**Brace Needed: _____**

**Primary Diagnosis: _____ Secondary Diagnosis: _____**

**Date patient last seen by ordering practitioner for item being ordered: _____**

**Have you ever received a brace through medical insurance? Yes ☐ No ☐**

**If yes, what type of brace and when? _____**

**Physician Name: _____ Phone #: _____**

**Office Location: _____ Fax #: _____**

**Has anyone discussed need for Hospice? Yes ☐ No ☐ If yes, details _____**

**Primary Insurance: _____ Phone #: _____**

**ID #: _____ Group #: _____**

**Employer: _____ Policy Holder: _____ DOB _____**

**Secondary Insurance: _____ Phone #: _____**

**ID #: _____ Group #: _____**

**Employer: _____ Policy Holder: _____ DOB _____**

***I agree all information is accurate and truthful to the best of my ability. I agree I have not had this brace within the last five (5) years through medical insurance and I also agree this is not a workman's comp related issue. I understand if any of this information is fraudulent, I will be responsible for the payment in full of my brace received through Transcend Medical. I also understand if I choose to omit the payment to Transcend Medical the debt will be turned over within 30 days to a collection agency.***

**Completed by: _____ Relationship to the Patient_____**

**Patient or Guardian Signature: _____ Date: _____**

**Transcend Medical Employee Initials_____**