



ORTHOTICS REPAIR/REFURBISHMENT

TODAY'S DATE: ____/____/____

PATIENT'S FULL NAME (LAST, FIRST, M.I.): _____

If your name has changed in the last five years, please print former name: _____

DATE OF BIRTH: ____/____/____ PHONE: (HOME) _____ (CELL) _____

STREET ADDRESS _____ APT# _____

CITY: _____ STATE: _____ ZIP: _____

LAST TIME SEEN BY DOCTOR IN THIS OFFICE: (MONTH/YEAR) ____/____ WHICH DOCTOR: _____

REASON FOR ORTHOTICS: _____

PLEASE PLACE YOUR ORTHOTICS WITH THIS SHEET INSIDE A BAG OR BAGGIE AND SEAL BEFORE GIVING TO SOMEONE AT THE DESK. You will be called when your repairs are completed and your orthotics are ready to be picked-up.

THANK YOU FOR YOUR COOPERATION!