PODIATRY ORTHOTIC REORDER

Today's Date: _____/_____/_____

PATIENT INFORMATION:

Name: (*First*) _____ (*Middle Initial*) ___ (*Last*) _____

Birth Date: _____/_____/_____ Weight: _____ Height: _____ Shoe Size: _____

Preferred Contact: *(check best contact)*

☐ Phone (_____) _____ - _____ ☐ Email _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

ORTHOTIC TYPE:

What type of orthotic are we ordering?

- ☐ Athletic
- ☐ Dress/casual
- ☐ Soccer/Cycling
- ☐ Ski/Snowboard
- ☐ Other: _____

ORDER REASON:

Please describe your reason for your order: _____

_____

SIGNATURES:

After receipt of this form, please allow 2 weeks for your new orthotics to arrive at our office. Additionally, insurance plans may vary in coverage for custom orthotics, and receipt of this form is not a guarantee of payment. Please understand your individual benefits prior to submitting this for reorder.

_____ _____/_____/_____

Patient – age 18 or older Month Day Year

_____ _____/_____/_____

Parent/Guardian – if patient is under age 18 Month Day Year

_____ _____/_____/_____

Reviewed By (PRO Medical Representative) Month Day Year

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