48531 Warm Springs Blvd. Fremont CA. 94539
Phone: 866.203.9810
Send Completed Form To:
Email: info@synergypo.com
Fax: 855.230.1468

# NEW DIABETIC SHOE PATIENT INTAKE FORM

## PATIENT INFORMATION

| Patient First Name | MI | Last Name | | |
|---|---|---|---|---|
| Date of Birth | Gender ☐ Male ☐ Female | | Social Security # | |
| Address | | City | State | ZIP |
| Phone Number | Alternate Number | | Email Address | |

## Medicare and Insurance

| Is Medicare your primary insurance? (Please check one) ☐ Yes ☐ No | Medicare Number: |
|---|---|
| If Not, List Primary Insurance Payer | |
| Primary Insurance ID# | Phone Number |
| Secondary Insurance Payer | |
| Secondary Insurance ID# | Phone Number |

## PHYSICIAN TREATING YOUR DIABETES (MD OR DO)

| Physician Name | Phone | Fax | |
|---|---|---|---|
| Address | City | State | Zip |

I authorize Synergy Prosthetics, Inc to contact my Physician to obtain a prescription for therapeutic shoes/inserts, my insurance company to verify my benefits and to contact me or my caregiver to discuss my order.

Patient Signature _____ Date _____

Caregiver Signature _____ Relationship to Patient _____

Send Completed form to: Email: info@synergypo.com