Alberta Orthotic & Prosthetic Centre

Alberta Orthotic & Prosthetic Centre
Suite 347, 3750 46 Avenue SE
Calgary AB T2B 0L1

Phone 403.244.2029
Fax 403.229.0820
info@aalonline.com

NAME LAST:_____FIRST:_____MIDDLE:_____

ADDRESS: _____CITY:_____

POSTAL CODE:_____EMAIL_____ GENDER: M____F____

DATE OF BIRTH#_____ HOME PHONE:_____

BUSINESS/CELL PHONE:_____FAX:_____

SPOUSE / EMERG CONTACT_____PHONE:_____

AB HEALTH #_____WCB CLAIM#_____

AISH #_____WAR AMPS REGISTERED? YES / NO

NIHB #_____ PHYSIO THERAPIST_____

FAMILY PHYSICIAN_____ ORTHOPEADIC SURGEON_____

DATE OF AMPUTATION_____ LEVEL OF AMPUTATION_____

I, THE UNDERSIGNED GIVE CONSENT TO ALBERTA ORTHOTIC & PROSTHETIC CENTRE, TO ASSESS AND BEGIN MY TREATMENT. I RECOGNIZE THAT ALL PERSONAL INFORMATION PROVIDED SHALL BE USED ONLY FOR THE PURPOSE OF PROVIDING ORTHOTIC OR PROSTHETIC SERVICES. I ALSO AUTHORIZE ALBERTA ORTHOTIC & PROSTHETIC CENTRE TO COLLECT OR OBTAIN MY MEDICAL INFORMATION (IF REQUIRED) TO AND FROM ANY RELATED PARTY WITH REGARD TO MY TREATMENT OR DEVICE.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ANY PROSTHETIC OR ORTHOTIC SERVICE NOT COVERED BY ANY OF THE ABOVE AGENCIES.

DATE:_____ SIGNATURE _____

If Patient is a Minor
First and Last Name of Parent/Legal Guardian_____

Best Phone # for contact_____Signature_____