Bay Orthopedic and Rehabilitation Supply Company Inc.

Visit www.bayorthopedic.com

Corporate Headquarters – 616 East Jericho Tpke. Huntington Station, N.Y. 11746

Regional Offices – Suffolk County, Nassau County, Queens County (NYC)

PATIENT INFORMATION

Patient Name ____ **Today's Date**____/____/_____

Patient Home Address ____

City ___________________________________ **State** _______________ **Zip Code**_______________

Date of Birth ____/____/_____ **Age** ______ **Height** ____**Ft.**____**In.** **Weight** ________**Lbs.**

Last 4 digits of SS # _________________ **Sex M/F** ______ **Marital Status: S M other**____

Home Phone (   ) _____ - ______________ **Cell Phone (   )**_____-______________

E-Mail ________________________________ **Work Phone (   )**_____- _____________________

Please check best telephone to contact you Home ___ **Cell** ____ **Work** ____

Occupation_________________________ **Employer Name /School**___________________________

Name of Person Insured ____________________________**Date of Birth of Insured** ____/____/____

Name of Insurance Co.________________________ **ID#**__________________**Phone (**____**)**___**-**______

Name of person with you during fitting ______________________ **Relationship** _____________

Name of closest relative in Case of Emergency _________________**Phone (   )**_____**-**________

What is the condition or illness that caused you to seek medical attention? _____________

____

What is the name of your referring doctor? _______________________**Phone (   )**_____**-**________

When is your next follow up visit with your referring doctor? ____________________

What is the name of your Primary Care Doctor? ____

Have you been to Bay Orthopedic before? Yes/No_____ **if yes how long ago?**______________

Are you Diabetic? Yes/No_______ **Have you smoked in last 3 months? Yes/No**_________

Are you allergic to any materials like latex, neoprene etc? Yes/No. If so what?___________

Do you have any circulation impairment? Yes/No _______ **Do you experience edema or swelling in any body parts? Yes/No** ______ **Where?**____

Do you have any previous knowledge of what was prescribed for you? Yes/No_____

Have you worn a device for this condition within the last 5 years? Yes/No_________

Do you have any medical condition or physical limitation that you think would interfere with the device your doctor has prescribed for you? Yes/No_____ **If the answer is yes please describe that condition**____

*** I CERTIFY THAT THE INFORMATION I PROVIDED IS TRUE & COMPLETE & AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM TO ANY INSURANCE COMPANY/ATTORNEY INVOLVED.**

*** I AUTHORIZE PAYMENTS DIRECTLY TO Bay Orthopedic & Rehab. Supply Co. Inc. IF ASSIGNMENT HAS BEEN ACCEPTED.**

*** I PERMIT A PHOTOCOPY OF THIS ASSIGNMENT/AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.**

*** I AM AWARE THAT COPIES OF THIS FORM AS WELL AS HIPAA PRIVACY PRACTICES AND MEDICARE SUPPLIER STANDARDS ARE POSTED IN THIS OFFICE & THAT IF I WANT A COPY THEY ARE AVAILABLE HERE OR ON BAY WEBSITE**

*** I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO Bay Orthopedic & Rehab. Supply Co. Inc FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY AND THAT I AM RESPONSIBLE TO PAY THESE BALANCES WITHIN 30 DAYS OR I WILL INCUR A SERVICE CHARGE OF 1 ½% PER MONTH AND COLLECTION AND ATTORNEY FEES INCURRED.**

*** SIGNATURE ON FILE: I AUTHORIZE Bay Orthopedic & Rehab. Supply Co. Inc. TO USE THE PHRASE SIGNATURE ON FILE ON ANY CLAIMS OR CREDIT CARD SLIPS IN ORDER TO PROCESS OR PAY FOR SERVICES RENDERED. MY SIGNATURE REMAINS EFFECTIVE UNTIL IT HAS BEEN REMOVED BY ME IN WRITING.**

*** THIS ASSIGNMENT OF BENEFITS AND THESE PAYMENT RULES HAS BEEN EXPLAINED TO MY FULL SATISFACTION.**

Signed by ____ **Print Name** ____________________________________**Date**_________

Policyholder/Authorized Person

Plagiocephaly Patient Evaluation Form

CLINICAL INFORMATION

Orthotist:

Date:

Patient Name:

Date of Birth:

Parent(s) Name(s):

Pediatrician Name: ____________________

Address: ____________________ **Phone:** ____________________

____

Referring Physician:

Documentation Provided:
- ❏ Prescription
- ❏ Letter of Medical Necessity
- ❏ Surgical Notes

BIRTH INFORMATION

Gender:
❏ Male ❏ Female

First Pregnancy?:
❏ No ❏ Yes

Size:
❏ Weight :________ Length: ________

Multiple Gestations:
❏ No ❏ Yes
❏ Twins ❏ Triplets ❏ Other

Gestational Age:
❏ Full Term ______ weeks
❏ Premature ______ weeks
*Time spent in neonatal intensive care ______ weeks

Fetal Positioning:
Any unusual positioning of the fetus during pregnancy? ❏ No ❏ Yes ____________________

Delivery:
❏ Vaginal ❏ Caesarean

Use of Delivery Aids:
❏ No ❏ Yes

Delivery:
Any problems with delivery? ❏ No ❏ Yes ____________________

Other Congenital Anomalies or Medical Conditions:
❏ None ❏ Congenital muscular torticollis ❏ Congenital hip dislocations ❏ Development delays
❏ Equinovarus ❏ Scoliosis ❏ Chronic ear infections
❏ Other ____________________

Head Shape at Birth:
❏ Symmetrical ❏ Asymmetrical ❏ Wide ❏ Long ❏ Other ____________________

Skin Sensitivity:
Any problems with persistent rashes or hypersensitivity? ❏ No ❏ Yes ____________________
Oral or topical agents used? ❏ No ❏ Yes ____________________

Age of Infant When Abnormal Head Shape First Observed:
❏ At Birth ❏ 1 – 2 Months ❏ 4 – 6 Months
❏ 0 – 2 Weeks ❏ 2 – 3 Months ❏ over 6 Months
❏ 2 – 4 Weeks ❏ 3 – 4 Months

First Person to Point Out the Abnormal Head Shape?
❏ Physician ❏ Parent / caregiver
❏ Nurse ❏ Family member / friend
❏ Physical Therapist ❏ Other ____________
❏ Occupational Therapist ____________

DEVELOPMENTAL OBSERVATIONS

Preferred Sleeping Positions:

❏ Back ❏ Tummy ❏ Side ❏ Mixed

Comments ______________________________

Repositioning for Abdominal Head Shape:

❏ No ❏ Yes

*Age started: _____ weeks *Duration _____ weeks *Still repositioning: ❏ No ❏ Yes

Comments ______________________________

Developmental Milestones:

Independent Head Control (*12 wks)	❏ No	❏ Yes	Comments ______________
Rolling Prone to Supine (*4-5 mos)	❏ No	❏ Yes	Comments ______________
Rolling Supine to Prone (*5 mos)	❏ No	❏ Yes	Comments ______________
Supported Sitting (*5 mos)	❏ No	❏ Yes	Comments ______________
Unsupported Sitting (*5 mos)	❏ No	❏ Yes	Comments ______________
Creeping (*7-8 mos)	❏ No	❏ Yes	Comments ______________
Crawling (*8-9 mos)	❏ No	❏ Yes	Comments ______________
Pulls to Stand (*8-9 mos)	❏ No	❏ Yes	Comments ______________
Walks Alone (*12 mos)	❏ No	❏ Yes	Comments ______________

Physical Therapist Name: ______________ **Phone:** ______________

Address: ______________________________

FOR OFFICIAL USE ONLY

DEVELOPMENTAL OBSERVATIONS

Identification of Head Deformation:

Observed by *family* at age ___________ weeks. Diagnosed by *physician* at age ___________ weeks.

Tests Performed:

❏ Clinical Evaluation ❏ X-Ray ❏ MRI ❏ CT Scan ❏ Other ______________

Classification of Head Deformity:

❏ Deformational Plagiocephaly ❏ Deformational Brachycephaly ❏ Deformational Scaphocephaly

❏ Post-Operative Craniosynostosis:

*❏ Plagiocephalic ❏ Brachycephalic ❏ Scaphocephalic

Palpation of Sutures:

❏ No Ridging ❏ Ridging *❏ Specify Location ______________

Anthropometric Measurement Form Completed:

❏ No ❏ Yes

Clinical Photographs Taken:

❏ No ❏ Yes

Using the scale below, rate the severity of the infant's head deformity:

❏ 0	❏ 1	❏ 2	❏ 3	❏ 4	❏ 5
None	Very Mild	Mild	Moderate	Severe	Very Severe

Using the scale below, <u>ask parent/caregiver</u> to rate the severity of the infant's head deformity:

❏ 0	❏ 1	❏ 2	❏ 3	❏ 4	❏ 5
None	Very Mild	Mild	Moderate	Severe	Very Severe