**Bay Orthopedic and Rehabilitation Supply Co. Inc.**
**Patient Information Update**

Patient's Name:_____
Height:_____ Weight:_____
Age:_____ Date of Birth:_____

Parent's Name:_____
Email Address:_____
City:_____ State:_____
Phone:_____

Has the patient worn any scoliosis brace? Y / N
If Yes, What type of brace?:_____
In girls, did patient start her menses? Y / N If so, when?_____
In boys, has voice changed? Y / N

**Risser Sign (if you know it):**

**Scoliosis diagnosis date:**

**Size of curves in the most recent x-rays (list in and out of brace)?**

**Date and type of last new brace (if someone else, please name orthotist)?**

**Date of the last follow up appointment via email and in-person with me?**

**Height change since last new brace fitting?**

***Note: It is critical to monitor closely the patient at 9, 12, and 15 months of wear so the brace is not too short for the patient. A short brace will have negative effects.***

## Image/Information Release

I hereby give Bay Orthopedic and Rehabilitation Supply Co. Inc. consent to obtain and release information and to photograph my child's image to be used in the following ways: **1)** Communicate with other scoliosis professionals (i.e. Dr Rigo, Schroth PTs, referring MD and others) **2)** Submit to insurance companies to meet coverage criteria

Signature:_____ Date:_____

Printed Name:_____ Relationship:_____