Patient Information

Name: ____ SS#: ________________

(Last) (First) (MI)

Birthdate: ______________ Age: ______ Sex: M F Marital Status: CH S M D W

Home Address: ____

(Street) (City) (State) (Zip)

Mailing Address: ____

Home Phone: ________________ Cell Phone: ______________ Work Phone: ____________

Employer Name: ______________ Employer Address: _______________________________

Email Address: ________________________ Preferred Pharmacy (include city): _____________

Family Physician: ______________________________ Phone #: _____________________

(Name) (City)

Please list any allergies the patient may have: ____

If the patient is a child, please provide the following information for the parent responsible for the bill:

Name: _________________ Relationship: _________ Birthdate: _________ SS#: _________

Address: ____

* If different from child

Home Phone: ______________ Cell Phone: ________________ Work Phone: ______________

Primary Insurance Company:_____________	**Secondary Insurance Company:** _____________
Policy Holder: ______________________	Policy Holder: ______________________
SS#: ___________ Birthdate: ___________	SS#: ___________ Birthdate: ___________
Relationship to patient: _______________	Relationship to patient: _______________

I authorize the release of any medical information necessary to process my claims.
I authorize payment of medical benefits directly to the physician for services rendered.
I understand that I am responsible for all co-payments, coinsurance and services deemed "non-covered" by my insurance.
I authorize my physician to act as my agent in assisting me to obtain payment from my insurance companies.
I acknowledge that I have received and/or reviewed a copy of Precision Orthopaedic Specialties, Inc's Notice of Privacy Practices.

(Signature of patient) (Date)

(Signature of legal guardian if patient is a minor) (Date)

HIPAA PRIVACY INFORMATION

PLEASE CHECK ALL THE WAYS WE CAN CONTACT YOU TO REMIND OF APPOINTMENTS.

____ HOME PHONE (TO INCLUDE AUTO CALL)?

____ MOBILE PHONE (TO INCLUDE AUTO CALL)?

____ TEXT MOBILE PHONE?

____ WORK PHONE?

____ IF SOMEONE ELSE ANSWERS CAN WE TALK TO THEM?

_X__ MAIL?

____ E-MAIL OR PATIENT PORTAL?

____ OK TO LEAVE MESSAGE?

PLEASE CHECK ALL THE WAYS WE CAN CONTACT YOU TO DISCUSS MEDICAL INFORMATION?

____ HOME PHONE?

____ MOBILE PHONE?

____ TEXT MOBILE PHONE?

____ WORK PHONE?

____ IF SOMEONE ELSE ANSWERS CAN WE TALK TO THEM?

_X__ MAIL?

____ E-MAIL OR PATIENT PORTAL?

____ OK TO LEAVE MESSAGE?

EMERGENCY CONTACT 1: Name: ____________________________ Relation: ________________

Home: ______________________ Cell: _____________________ Work: ______________________

EMERGENCY CONTACT 2: Name: ____________________________ Relation: ________________

Home: ______________________ Cell: _____________________ Work: ______________________

ARE WE ALLOWED TO SPEAK WITH YOUR EMERGENCY CONTACTS ABOUT APPOINTMENT AND MEDICAL INFORMATION?
____ Yes ____ No

____ ____________________
PATIENT SIGNATURE DATE