

TRI-COUNTY ORTHOPEDIC & SPORTS MEDICINE

PATIENT INFORMATION					
NAME: LAST	FIRST	MIDDLE	Date of Birth:	Sex:	
ADDRESS: Street/Box	CITY	STATE	ZIP	Social Security Number:	
HOME PHONE: ()	WORK PHONE: ()	CELL PHONE: ()	E-MAIL ADDRESS:		
WHO REFERRED YOU TO THIS OFFICE?	WHO IS YOUR FAMILY DOCTOR?	PREFERRED PHARMACY:			
MARITAL STATUS:	SPOUSE'S NAME: LAST	FIRST	MIDDLE	SPOUSE'S SOCIAL SECURITY #:	
SPOUSE'S DOB:					
EMPLOYER INFORMATION					
PATIENT'S EMPLOYER:	EMPLOYER'S ADDRESS:	CITY	STATE	ZIP	
SPOUSE'S EMPLOYER:	SPOUSE'S EMPLOYER'S ADDRESS:	SPOUSE'S WORK PHONE: ()			
EMERGENCY CONTACT (NOT LIVING WITH YOU):					
NAME OF PERSON AND ADDRESS:					
RELATIONSHIP:	HOME PHONE: ()	WORK PHONE: ()	CELL PHONE: ()		
FOR CHILDREN ONLY					
FATHER'S NAME:			MOTHER'S NAME:		
SS#:	Date of Birth:	SS#:	Date of Birth:		
ADDRESS (IF DIFFERENT THAN PATIENT):			ADDRESS (IF DIFFERENT THAN PATIENT):		
HOME PHONE: ()	CELL PHONE: ()	HOME PHONE: ()	CELL PHONE: ()		
FATHER'S EMPLOYER NAME & PHONE NUMBER:			MOTHER'S EMPLOYER NAME & PHONE NUMBER:		

INSURANCE INFORMATION: Please allow us to photocopy your insurance cards

Primary Insurance: _____ Secondary Insurance: _____

I hereby authorize Tri-County Orthopedic & Sports Medicine to treat me as a patient. Additionally, they may release necessary information to my insurance carriers in the event a claim is made. I assign to the doctors all payments for medical services rendered to my dependents or myself. I understand that I am personally responsible for this account and that payment is expected when services are rendered unless other arrangements have been made in advance.

Signature of Patient/Guardian

Date

ACCIDENT OR ONSET INFORMATION

If NOT an injury, when did your symptoms first occur? _____

DATE OF INJURY: _____

Where did the accident happen? _____

Explain in detail how the injury occurred: _____

Is this injury related to an auto accident? Yes No

Is this injury work related? Yes No

If work related, list employer name, address, phone number and contact person:

Employer: _____ Contact person: _____

Address: _____ Phone number: _____

Who is responsible for the charges: _____

Patient/Guardian Signature

Date

PRIVACY & FINANCIAL POLICY ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have received a copy of Tri-County Orthopedic & Sports Medicine's Privacy & Financial Policies.

Signature of Patient or Patient's Representative & Relationship

Date

AUTHORIZATION TO RELEASE PHI TO FAMILY OR OTHER AUTHORIZED REPRESENTATIVES

I authorize the following people to discuss or receive protected health information on my behalf:

NAME

RELATIONSHIP

****NOTE:** Tri-County Orthopedic & Sports Medicine may, as allowed by the HIPAA Privacy Rule, release medical information to another treating medical facility without additional written authorization.