TRI-COUNTY ORTHOPEDIC & SPORTS MEDICINE

Medical Record#____________

PATIENT INFORMATION

NAME: LAST	FIRST	MIDDLE	Date of Birth:
ADDRESS: Street/Box	CITY	STATE ZIP	Social Security Number:
HOME PHONE: ( )	WORK PHONE: ( )		CELL PHONE: ( ) E-Mail Address:
WHO REFERRED YOU TO THIS OFFICE?			MARITAL STATUS:
WHO IS YOUR FAMILY DOCTOR?			SPOUSE'S Social Security Number:
SPOUSE'S NAME: LAST	FIRST	MIDDLE	SPOUSE'S DATE OF BIRTH:

EMPLOYER INFORMATION

EMPLOYER:		WORK PHONE: ( )	
EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP:
SPOUSE'S EMPLOYER:		WORK PHONE: ( )	
SPOUSE'S EMPLOYER'S ADDRESS:	CITY:	STATE:	ZIP:

FOR CHILDREN ONLY

FATHER'S NAME:		MOTHER'S NAME:	
SS#	Date of Birth:	SS#:	Date of Birth:
HOME PHONE: ( )	WORK PHONE: ( )	HOME PHONE: ( )	WORK PHONE: ( )
ADDRESS:		ADDRESS:	
EMPLOYER & PHONE:		EMPLOYER & PHONE:	

EMERGENCY CONTACT (*NOT* LIVING WITH YOU):

NAME OF PERSON & ADDRESS: RELATIONSHIP:	
HOME PHONE: ( )	WORK PHONE: ( )

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:________________________

PRIVACY POLICY ACKNOWLEDGEMENT OF RECEIPT

I ______________________________ acknowledge that I have received a copy of
Patient Name

Tri-County Orthopedic & Sports Medicine's Privacy Policies. The Notice describes how Tri-County Orthopedic & Sports Medicine may use and disclose my protected health information, certain restrictions on the use and disclosures of my healthcare information, and rights I may have regarding my protected health information.

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(Signature of Patient or Patient Representative) (Date)

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(Relationship to Patient)

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

Financial Policy Acknowledgement of Receipt and Agreement

I acknowledge that I have received and agree to the financial policy of Tri-County Orthopedic & Sports Medicine.

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Signature of Patient or Patient Representative

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Relationship to Patient