

# ORTHOPEDIC GROUP, INC.

PLEASE PRINT CLEARLY

PATIENT INFORMATION SHEET

PATIENT'S NAME: \_\_\_\_\_ GENDER:  MALE  FEMALE

MARITAL STATUS:  SINGLE  MARRIED  DIVORCE  SEPARATED  WIDOWED  PARTNER

RACE:  WHITE  BLACK  HISPANIC  AMERICAN  INDIAN ASIAN  OTHER SSN: \_\_\_\_\_

ETHNICITY:  HISPANIC/LATINO  NON-HISPANIC/LATINO BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER/SCHOOL (IF STUDENT): \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENT(S) OR LEGAL GUARDIANS:

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

BILLING ADDRESS (IF DIFFERENT THAN ABOVE): \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WAS THE INJURY/CONDITION INCURRED AT, OR A RESULT, OF:  WORK  AUTO ACCIDENT  SLIP & FALL

INJURY IN/ON PUBLIC OR PRIVATE PROPERTY (OTHER THAN YOUR OWN)  NONE OF THESE

DO YOU HAVE AN ATTORNEY REPRESENTING YOU IN REGARDS TO THIS INJURY?  YES  NO

IF YES, WHO? \_\_\_\_\_ PHONE: \_\_\_\_\_

YOUR PERSONAL/PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ INSURANCE ID #: \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ INSURANCE ID #: \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

## PHARMACY INFORMATION

PHARMACY NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

## IN CASE OF EMERGENCY, NOTIFY

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

If the patient is over age 18, has he or she established an advance directive?  YES  NO  DON'T KNOW

I acknowledge that I have received a copy of Orthopedic Group, Inc.'s Notice of Privacy Practices.

Sign \_\_\_\_\_ Date \_\_\_\_\_