PATIENT INFORMATION

Is today's visit for? ☐Personal Injury ☐Sports Injury ☐Work Related Injury ☐Auto Accident ☐Other

Full Name: _____ Preferred Name: _____

Social Security #: _____ Sex: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____

Marital Status: _____ Race: _____ Language: _____

Who is responsible for the bill (Name): _____ Address: _____

Phone: _____ Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____

PATIENT or GUARANTOR EMPLOYER INFORMATION

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student ☐Other

Employer: _____ Job Title: _____

Address: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name: _____

Subscriber Name: _____

Subscriber's Phone #: _____

Relationship to patient: _____

Employer: _____ DOB: _____

Group #: _____ Member #: _____

Secondary Insurance

Insurance Name: _____

Subscriber Name: _____

Subscriber's Phone #: _____

Relationship to patient: _____

Employer: _____ DOB: _____

Group #: _____ Member #: _____

EMERGENCY CONTACT / HIPAA AUTHORIZATION

In the event of any emergency, please contact the person listed below. If left blank, OrthoCincy will assume you do not want us to contact anyone in the event of an emergency.

Check the box next to the names of those who you wish to authorize to obtain your personal medical information. If left unchecked, OrthoCincy will assume you do not want us to release your medical information to anyone.

Name:	DOB:	Relationship:	Phone:	HIPAA?
				☐
				☐
				☐
				☐

Patient Signature: _____ Date: _____

To ensure confidentiality and privacy, any type of electronic recording or photography is strictly prohibited at any location within OrthoCincy offices.