Name:

DOB:

OrthoCincy

Date:

Patient Information

Full name: _____ Preferred Name: _____ Sex: _____

DOB: _____ Marital Status: _____ Social Security #: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other

Employer: _____ School: _____

Referring Doc: _____ Family Doc: _____

Responsible Party, if Patient is Under 18

Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Employer: _____ Phone: _____

Insurance Information

Primary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Subscriber Name: _____ DOB: _____ Relationship to Patient: _____

Additional Information

Primary Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Decline

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline

Emergency Contact: _____ Phone: _____

Residential Information

Are you currently living at: ☐ Home ☐ Nursing Home/Facility Name: _____

Pharmacy Information

Pharmacy: _____ Location: _____

Is Today's Visit for a Work Related Injury or Auto Accident? ☐ Yes ☐ No

HIPAA Authorization

I authorize the person/people listed below to obtain medical information about myself. If left blank, we will assume you do not want us to release your medical information.

Name: _____ DOB: _____

Name: _____ DOB: _____

Patient's Signature: _____ Date: _____