Name:

DOB:

Date:

Patient Information

Full name: _____ Preferred Name: _____ Sex: _____

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

Address: _____ City: _____ State: _____ Zip: _____

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: _____

SSN: _____ 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

Residential Information

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

Pharmacy Information

Pharmacy: _____ Location: _____

Is Today's Visit for?

☐ Work Related Injury ☐ Auto Accident

HIPAA Authorization and Emergency Contact

I authorize the person/people listed below to be called in the event of an emergency. They are also permitted to obtain medical information about myself. If left blank, OrthoCincy will assume you do not want us to release your medical information to anyone and/or contact anyone in the event of an emergency.

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

Patient/Guardian Signature: _____ Date: _____

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