Date ___ / ___ / ____

Seacoast Orthopedic Associates

Patient Information Sheet

Legal Name: _____ I prefer to be called: _____

Date of Birth: _____ Sex: ___ Male ___ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native American Indian ☐ Other: _____

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

Best phone number to reach you: _____

Email Address: _____ Preferred Language for healthcare: _____

Primary Care Physician: _____ Chief complaint: _____ ☐Right ☐Left

Date of accident: _____ ☐Auto ☐Work If work related; employer name: _____

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1. <u>HIPAA</u> - Person (spouse/domestic partner, sibling, child etc.) authorized to contact SOA on my behalf:

Name: _____ Relationship: _____ Phone number: _____

Regarding: (**Please check all that apply**)

☐Appointments: Ability to make, change or cancel appointments on my behalf

☐Billing Questions/payments

☐Medical Records: Including but not limited to: office visits, MRI reports, lab work

<u>OR:</u> ☐Do not discuss my medical record with anyone

I understand that this authorization is in place until I revoke it by notifying Seacoast Orthopedics in writing.

2. <u>Emergency Contact</u> - Check and initial here if same as above ☐_____

Name: _____ Relationship: _____ Phone number: _____

****Please note the Emergency Contact will *<u>not</u>* have access to your appointments, medical records, or billing****

I authorize Seacoast Orthopedics to leave detailed messages on the phone number(s) I have listed above.

To opt <u>out</u> of voicemails initial here: _____

I consent to have Seacoast Orthopedic Associates Physicians, mid-level providers and other staff members under the direction of the physicians treat me. Treatment may include Physical Examination, Diagnostic Procedures and Prescription of Medications. I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of Medical Benefits for myself to Seacoast Orthopedic Associates. I authorize payment of medical benefits for myself to Seacoast Orthopedic Associates and authorize the release of any medical information necessary to process this claim. I have read this form or have had it read to me. I further acknowledge to have been made aware of the Notice of Privacy Policy.

Signature: _____ Date: ___/___/_____

Please return to the desk once all 3 pages are completed in order to be checked in for your appointment.