Ortho Rhode Island

Date____________________________

PATIENT INFORMATION:

Name: ____ DOB: ____/____/____ ☐Male ☐Female ☐Undefined

Mailing Address: _____________________________________ City: ________________ State: _____ Zip: __________

Billing Address (if different from above): ____

Phone #s: Primary: home / cell (______)___________________ Secondary: home / cell (______)_________________

E-mail Address: ____

Preferred Language: _________________Race: _____________________ Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino

Marital Status: ________________________________ Social Security Number: _____________________________

Employer/School: ☐Retired ____ Phone: (______)_______________

Address:_________________________________City:_______________________ State:______ Zip: ____________

If patient is a minor:

Parent/Guardian: ____ DOB: _____/_____/_____

MEDICAL INFORMATION:

Primary Care Physician: ____Phone: (______)_________________

Pharmacy: ___________________________ Location: ________________________ Phone: (______)_______________

INJURY INFORMATION:

Is this a work related injury? ☐YES ☐NO

Insurance Carrier: ____ Claim #: ______________________________

Adjuster information: Name: ______________________________________ Phone: (______)____________________

INSURANCE INFORMATION:

Primary Insurance: _____________________________________ Insurance ID #: ______________________________

Secondary Insurance: ___________________________________ Insurance ID #: ______________________________

Policy Holder's Name: ____ Date of Birth: _____/______/______

EMERGENCY CONTACT:

Name: ____ Relationship to Patient: ________________________

Phone #s: Primary: home / cell (______)___________________ Secondary: home / cell (______)_________________

By signing below, I acknowledge that I have read a copy of the Orthopedics Rhode Island Notice of Privacy Practices and a copy is available upon request. I have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information. By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature: ____ Date: __________________________

FOR OFFICE USE ONLY: ☐ INSURANCE CARD SCANNED ☐ PHOTO ID SCANNED EMPLOYEE INITIALS________________________