Ortho Rhode Island
Caring for your every move.

New Patient Form

Date: _____

Patient Information

Name: _____ DOB: ___/___/___ ☐ Male ☐ Female ☐ Undefined

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

Billing Address (if different from above) _____

Home: _____ Work: _____ Cell: _____

Email: _____

Preferred Language: _____ Race: _____ ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Marital Status: _____

Employer/School: ☐ Retired _____ Phone: _____

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

Medical Information

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Insurance ID# _____

Secondary Insurance: _____ Insurance ID# _____

Policy Holder's Name: _____ DOB: ___/___/___

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone Numbers Home: _____ Work: _____ Cell: _____

If patient is a minor: Parent/Guardian _____ DOB: ___/___/___

Injury Information

Was this injury/condition incurred at, or a result of:

☐ Work ☐ Auto Accident ☐ Injury at/on public property other than your own ☐ None of these

Do you have a lawyer representing you in regards to this injury? ☐ Yes ☐ No

Lawyer information Name: _____ Phone: _____

May we discuss your medications(s)/conditions(s) with any member of your family? ☐ Yes ☐ No *If YES, please name the members allowed below*

Name (s): _____ Relationship (s): _____

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. I also authorize Orthopedics Rhode Island to leave non-clinical messages in reference to any items that assist in carrying out my healthcare. The best number to reach me is my: ____ Home ____Cell ____Work

Signature: _____ Date: _____