DATE:_____

Paris Orthopedic Clinic, P.A.

Patient Information

PLEASE FILL OUT COMPLETELY!

PERSONAL INFORMATION

Patient Name: _____ (Last / First / Middle) Gender: ___ Doctor: _____

Address: _____ (Street and/or P.O. Box / City / State / ZIP)

Patient D.O.B: _____ SS#: _____ Phone 1: _____

Marital Status: M S W D DL#: _____ (State) Phone 2: _____

This information is a requirement of the Affordable Care Act

Language Spoken: _____

Race? ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ Native American ☐ Other_____

Ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Email Address (PLEASE PRINT CLEARLY): _____

Employer: _____ Phone: _____

Employer's Address: _____ (Street and/or P.O. Box / City / State / ZIP)

Spouse's Name: _____ Phone: _____

Contact Not Living with You: _____ Phone: _____

IF PATIENT IS A MINOR:

Father: _____ Phone: _____

Father's DOB: _____ SS #: _____ Phone: _____

Mother: _____ Phone: _____

Mother's DOB: _____ SS #: _____ Phone: _____

HEALTH INFORMATION

Problem Being Seen For: _____ **RIGHT or LEFT**

If Accident, Please Describe: _____ **Date of Accident:** _____

Referring Physician: _____ Phys. Phone: _____

Which E.R. Were You Seen In? _____ PCP's Name: _____

Is This a Worker's Comp Injury? ___ YES ___ NO **Pharmacy:** _____ Street & City: _____

PRIMARY INSURANCE

Insurance Company: _____ Phone: _____

Policy / ID # : _____ **Group # :** _____

Employer: _____ Phone: _____

Policy Holder's Name: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's DOB: _____ SS #: _____ Phone: _____

Policy Holder's Address: _____ (Street and/or P.O. Box / City / State / ZIP)

SECONDARY INSURANCE

Insurance Company: _____ Phone: _____

Employer: _____ **Policy / ID # :** _____ **Group # :** _____

Policy Holder's Name: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's DOB: _____ SS #: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY

Responsible Party's Name: _____ Patient's Relationship to Guarantor: _____

Resp Party's DOB: _____ SS #: _____ Phone: _____

Address: _____ (Street and/or P.O. Box / City / State / ZIP)

SIGNATURE

I affirm the information stated above is true and correct to the best of my knowledge. I hereby authorize Paris Orthopedics & Sports Medicine to release information acquired in the course of my treatment for the purpose of obtaining insurance benefits. I understand that in the event the liable party does not pay my medical expenses I will be responsible for all charges. I also hereby authorize payment to be made directly to Paris Orthopedics & Sports Medicine for services that would otherwise be payable to me. I also authorize Paris Orthopedics & Sports Medicine to acquire any and all of medical records including my prescription medication history from other healthcare providers or th ird party pharmacy database for medical treatment purposes. Paris Orthopedics & Sports Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature of Patient or Legally Authorized Representative: X_____