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#: _____ Home Phone: ( ) _____

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

This information is a requirement of the Affordable Care Act (ObamaCare)

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: _____ Work Phone: ( ) _____

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

Spouse's Name: _____ Work Phone: ( ) _____

Contact Not Living with You: _____ Phone #: ( ) _____

IF PATIENT IS A MINOR:

Father: _____ Home #: ( ) _____

Father's DOB: _____ SS #: _____ Work #: ( ) _____

Mother: _____ Home #: ( ) _____

Mother's DOB: _____ SS #: _____ Work #: ( ) _____

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? _____ Doctor'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: _____ Relation to Patient: _____

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: _____ Relation to Patient: _____

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

FINANCIALLY RESPONSIBLE PARTY

Responsible Party's Name: _____ Relation to Patient: _____

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 Orthopedic Clinic, P.A. 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 Orthopedic Clinic, P.A. for services that would otherwise be payable to me. I also authorize Paris Orthopedic Clinic, P.A. to acquire any and all of medical records including my prescription medication history from other healthcare providers or third party pharmacy database for medical treatment purposes.

Signature of Patient or Legally Authorized Representative: X _____