

**Piedmont Orthopaedic Associates, P.A.**

**Patient Information Form**

P L E A S E P R I N T

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Do you live in a skilled Nursing Facility? \_\_\_\_yes \_\_\_\_no.  
Name of facility: \_\_\_\_\_

***Employer:***

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

***If Patient Is A Minor:***

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ SS #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

***Referring Doctor:*** \_\_\_\_\_ ***Family Doctor:*** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

***Was this an on the job injury?*** \_\_\_\_ Yes \_\_\_\_ No

Description of Problem: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

How did injury happen? \_\_\_\_\_

Employer at time of accident: \_\_\_\_\_ Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_ Worker's Compensation Insurance: \_\_\_\_\_

***Insurance:***

***Primary:*** \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ ID#: \_\_\_\_\_ Employer: \_\_\_\_\_

***Secondary:*** \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ ID#: \_\_\_\_\_ Employer: \_\_\_\_\_

**PAYMENT IS REQUIRED AT TIME OF SERVICE:**

Payment for medical care is solely the responsibility of the patient or his/her legal guardian. By signing below I give Piedmont Orthopaedic Associates, PA authorization to treat my medical condition. I also allow them to release my medical information as is necessary for treatment, payment and operation of Piedmont Orthopaedic Associates, P.A.

Patient or Legal guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT FINANCIAL POLICY:**

I have read and understand Piedmont Orthopaedic Associates, PA "Patient Financial Policy" and I agree to all terms listed in the policy.

Patient or Legal guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:**

I understand that the purpose of this notice is to inform me of my rights in regards to my "Protected Health Information" and also the ways in which Piedmont Orthopaedics may use my Protected Health Information. I also understand that Piedmont Orthopaedic Associates has my permission to use my Protected Health Information as necessary for treatment, payment and /or operation.

***Patient or LegalGuardian's Signature:*** \_\_\_\_\_ **Date:** \_\_\_\_\_