

**PATIENT INFORMATION SHEET**

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

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Zip: \_\_\_\_\_ Sex: \_\_\_\_\_ Soc Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Email address: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ DOB \_\_\_\_\_

**EMERGENCY contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

*Party responsible for account (If Work Comp or Auto provide that information)*

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB \_\_\_\_\_

Responsible person's employer: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

*Additional Insurance*

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

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

Attorney's name (if applicable) \_\_\_\_\_ Phone: \_\_\_\_\_

Major credit card type and number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

There may be instances that your health care provider may wish to communicate some aspects of your protected health information and or account information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Non-Surgical Orthopaedics, PC cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Non-Surgical Orthopaedics, PC to communicate my information electronically.  Yes  No

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopaedics, P.C. (NSO) and The Center for Spine Procedures, P. C. (CSP) to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I acknowledge that I understand by the policies of the practice of NSO as read in the Practice Handbook, and will be bound by the provisions contained in the Handbook. I also authorize the practice to release any medical information or insurance information that requested by any physical therapy, diagnostic imaging or clinical research facility that the practice refers me to as part of my treatment.

Patient (Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_