

2006

Midlands Orthopaedics, p.a.

Patient Acct. No \_\_\_\_\_ Doctor \_\_\_\_\_ Date \_\_\_\_\_

Is this visit due to an accident?

[ ] YES [ ] NO If yes: \_\_\_ Motor Vehicle \_\_\_ Work Related \_\_\_ Other?

( PATIENT INFORMATION ) E-mail Address: \_\_\_\_\_

Form with fields: LAST NAME, FIRST, MIDDLE INITIAL, DATE OF BIRTH, SOCIAL SECURITY#, MARITAL STATUS, GENDER, ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE, PATIENT'S EMPLOYER, PATIENT'S OCCUPATION, FULLTIME OR PART TIME, WORK PHONE, IS THE PATIENT A STUDENT?, IF YES, NAME AND CITY OF SCHOOL, CELL PHONE, IN CASE OF EMERGENCY, RELATIONSHIP TO PATIENT AND PHONE #

( INSURANCE INFORMATION )

Form with fields: INSURANCE #1 (PRIMARY INSURANCE), INSURANCE #2 (SECONDARY INSURANCE), INSURED'S NAME, RELATIONSHIP TO PATIENT, SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT), DATE OF BIRTH OF INSURED, INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT), PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR OR STUDENT, RESPONSIBLE PARTY INFORMATION (ADDRESS, TELEPHONE NUMBER, SSN)

Form with fields: HAS PATIENT SEEN AN ORTHOPAEDIST / NEUROSURGEON FOR THIS PROBLEM?, HAS PATIENT HAD X-RAYS FOR THIS PROBLEM?, IF YES, WHERE \_\_\_\_\_

RELEASE OF PRIVATE HEALTH INFORMATION NOTICE / AUTHORIZATION

Copies of your records pertaining to today's visit (and subsequent visits for the same problem) may be shared with the referring physician, family physician, school athletic director, and/or any other party you list on the "General Medical Information" sheet pertaining to the same problem. By initialing this, you authorize MOPA to do so; by initialing "restriction", you restrict MOPA from sending medical information without your specific direction.

\_\_\_\_ I authorize records be sent as outlined above \_\_\_\_\_ (patient's initials) \_\_\_\_\_ (date)

\_\_\_\_ I do not authorize the release of my records. The following restrictions apply: \_\_\_\_\_

MOPA employee initials \_\_\_\_\_