



Patient Information Form

Chart# _____

Patient Name _____
LAST FIRST MIDDLE

Address _____
STREET, P.O. BOX AND OR SUITE #

_____ CITY STATE ZIP

Home Phone # _____ Cell # _____ Work # _____

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Primary Ins. Carrier _____

Patient ID # _____ Policy # _____

Secondary Ins. Carrier _____

Patient ID # _____ Policy # _____

Please fill out the name of the primary cardholder of your insurance if it is different from the patient above.

Name _____
LAST FIRST MIDDLE

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Work # _____

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____ hereby authorize the physician and staff of Powell Orthopedics, P.A. to contact in case of emergency, or to discuss any information about health, well being, or appointments concerning the patient, with myself or spouse or with the following person or people.

1. Name _____ Phone # _____

2. Name _____ Phone # _____

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any information needed. I also agree to an automated telephone system to call and remind me of a scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party payer, hospital or physician any and all information it may have concerning the patient, including, but not limited to, medical history, reports, consultations, prescriptions, treatment, x-rays, and all other requested information or documentation pertaining shall be considered as a valid and effective as the original.

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN Date _____