PATIENT INFORMATION FORM

Primary Care Physician: _____**Referring Physician:** _____

Email: _____ Pharmacy Name/Location: _____

Last Name: _____ First Name: _____ Middle: _____

Local Address: _____
Street City State Zip Code

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: __M __F SSN _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: M S D W Spouse Name_____

Occupation: _____ Employer: _____
Employer Address: _____
Work Phone Number: _____

Insurance Information

Primary Insurance:
Ins. Co Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____

Secondary Insurance
Ins. Co Name: _____
Policy Holder Name: _____
Policy Holder DOB: _____

Emergency Contact Information

Name of person not living with you: _____Relationship: _____
Phone Number: _____
Address: _____

I authorize the release of health information to any physician directly involved in my treatment. I authorize the payment of medical benefits to the physician for services described on the claim for benefits form and authorize the release of any information necessary to process the claim. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or my personal information. _____**PLEASE INITIAL HERE.**

Please list below all parties we are authorized to speak with regarding your account and medical information: (Ex: Name of spouse, Name of mother)

_____ _____ _____

Prior to using or disclosing your protected information to carry out treatment, payment, or health care operations, NORTH ORLANDO SURGICAL GROUP is required by law to obtain consent. Please review this consent. If you understand and agree with its terms, please sign and date this consent below. By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment, or healthcare operation. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. We are not required to agree to such operations. You are also authorizing us to check your external prescription history as needed.

Privacy Practice Acknowledgement

_____ _____
Patient Signature Date