



North Orlando Surgical Group

Excellence is our standard of care

PATIENT INFORMATION

Primary Care Physician: Referring Physician:

Pharmacy: Email:

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 If Married, Spouse's Name

Occupation: Employer:

Employer Address:

Work Phone Number:

Primary Insurance:

Secondary Insurance:

Ins. Co Name:

Ins. Co Name:

Policy Holder Name:

Policy Holder Name:

Policy Holder DOB:

Policy Holder DOB:

Are you Enrolled in Hospice Care: Yes No If yes, for what diagnosis:

EMERGENCY CONTACT INFORMATION

Name of person not living with you: Relationship:

Address: Phone Number:

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)

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 operations. 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.

Patient Signature

Date



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Privacy Practice Acknowledgement

Receipt of HIPAA Notice of Privacy Practices Written Acknowledgement Form

To review or obtain a copy of our privacy practices, please visit www.northorlandosurgical.com

I am a patient of North Orlando Surgical Group (“NOSG”). I hereby acknowledge receipt of NOSG’s Notice of Privacy Practices.

Signature: _____ Date: _____

I am a parent or legal guardian, Relationship to patient: _____

ADVANCED DIRECTIVES

Do you have an Advanced Directive currently in place? Yes No

If you have an **Advance Directive**, it is your responsibility to provide a copy of the document to any organization you are seeking medical/behavioral health services at the time of intake or as soon as possible following your intake. The document will then be placed in a prominent location in your medical record. If you ever revoke or change your Advance Directive, you must inform the office as soon as possible so your information can be updated in your medical record.

To be completed by the patient/Responsible adult

I have been asked about having an Advanced Health Care Directive, and I have been given or offered an Advanced Health Care Directive fact Sheet

Patient Signature: _____ Date: _____

For more information about Advanced Directives, please visit www.caringinfo.org

To be completed by staff

The patient was given a copy of the Advanced Health Directive fact sheet at the face to face or clinic visit. Yes No

If no, please indicate why the patient was not given this information:

Patient declined Patient has an Advanced Directive currently in place Other _____