

**PATIENT INFORMATION FORM**  
Please print and complete ALL entries

Patient Name		Date of Birth	Marital Status	
Address		Home Phone	Social Sec. #	
Employer		Occupation	Work Phone	Ext.
Spouse's Name		Date of Birth	Soc. Sec.#	
Spouse's Employer		Work Phone		

**PARENTS IF MINOR**

Mother		Date of Birth	SS#	Home Phone
Address (if different from patient's)				
Employer		Work Phone		
Father		Date of Birth	SS#	Home Phone
Address (if different from patient's)				
Employer		Work Phone		

Contact in case of emergency	Relationship	Phone
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Whom may we thank for referring you to us?

Family Physician	Family Dentist
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PRIMARY INSURANCE _____	SECONDARY INS. _____
NAME OF INSURED _____	INSURED _____
RELATION TO PT. _____	RELATION TO PT. _____

PLEASE PRESENT ALL INSURANCE CARDS AND INFORMATION TO RECEPTIONIST!

THANK YOU.

PLEASE READ AND SIGN ONE OF THE BELOW: (If you have Medicare coverage and another secondary coverage, please sign both).

MEDICARE PATIENTS:

(G) Direct Payment Request and Authorization to Release Medical Information

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lawrence County Orthopedics and Sports Medicine for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

ALL OTHER INSURANCE:

(H) Direct Payment Request and Authorization to Release Medical Information

"I request that payment of authorized benefits be made to me or on my behalf to Lawrence County Orthopedics and Sports Medicine for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Lawrence County Orthopaedics & Sports Medicine.

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Signature of patient  
(or patient's personal representative)

\_\_\_\_\_  
Date of receipt

Personal representative information (if applicable):

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient (or other authority)