

Bayside Orthopaedic, Sports Medicine & Rehabilitation Center
Please PRINT – All information must be completed.

PATIENT INFORMATION

Name (first, M.I., last): _____

Date of Birth: _____ Age: _____ Male / Female Your Social Security Number _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell # _____

Referring Physician: _____ City _____ Phone _____
First Name.....Last Name

Your Primary Care Physician: _____ City _____ Phone _____
First Name.....Last Name

Preferred Pharmacy: _____ City _____ Phone _____

Parent / Spouse Name: _____ Date of Birth: _____ Relationship: Parent Spouse

Emergency Contact: _____ Relationship: _____ Phone #: _____
(someone outside of home)

Race: (Circle One) White Black/African American More than One Race American Indian Asian

Ethnicity: (Circle One) Hispanic/ Latino Not Hispanic/Latino Undefined Unreported

Insurance Information – Copies of Front and Back of each card will be scanned by our Receptionist

Insurance Subscriber Name _____ Date of Birth _____

RELEASE AND ASSIGNMENT, GUARANTEE OF PAYMENT AND PRIVATE HEALTH INFORMATION NOTICES

1. By signing below, I am authorizing this physician and practice's staff to treat me for my orthopaedic conditions.
2. I authorize the release of my medical information to treating or referring physicians.
3. I authorize the release of medical information to insurance companies or other pertinent parties to process payments.
4. I authorize and request payment of medical benefits directly to my physician.
5. I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing.
6. I authorize the use of a fax in order to submit medical information to pertinent parties.
7. I agree that a photocopy of this form may be used in lieu of the original.
8. I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 60 days.
9. I understand that the HIPAA Privacy Notice is posted, and I may have a copy if I request it.

From time to time, our doctors or staff may need to reach a patient directly concerning an appointment, test results, pathology reports, or medical information. It is at the patient's discretion when and with whom we share this information. This is due to HIPAA (Health Insurance Portability and Accountability Act of 1996). I authorize Bayside Orthopaedic & Rehabilitation Center physicians and staff to release information concerning me to whomever I have listed below:

___ Myself only ___ My answering machine ___ Those listed below

1. Name _____ Relationship _____ Phone # _____
2. Name _____ Relationship _____ Phone # _____

Patient Signature _____ Date _____