TRI-STATE ORTHOPAEDICS
& ORTHOPAEDIC URGENT CARE

PATIENT INFORMATION & DEMOGRAPHICS

Name *(Last)*: _____ *(First)*: _____ *(MI)*: ____ Preferred: _____

Birthdate: _____/_____/_____ SSN #: _____/____/_____ Sex: ☐ M ☐ F Marital status: ☐ M ☐ S ☐ D ☐ W

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other: _____ ☐ Decline to answer

Do you live in a nursing home, assisted living, or skilled nursing facility? ☐ Y ☐ N Facility: _____

Home address: _____ City: _____ ST: _____ Zip: _____

Cell phone #: (_____) _____ - _____ Home #: (_____) _____-_____ Email: _____

Employer/School: _____ City: _____ ST: _____ Phone#: (_____) _____-_____

COMMUNICATION PREFERENCES

Preferred method of communication: ☐ Text ☐ Phone ☐ Email ☐ Mail

Is there someone involved in your care that you authorize our office to communicate with on your behalf? ☐ Y ☐ N

If yes ~ Name: _____ Relationship: _____ Phone #: (_____) _____-_____
Name: _____ Relationship: _____ Phone #: (_____) _____-_____

Emergency contact: _____ Relationship: _____ Phone #: (_____) _____-_____

FINANCIAL RESPONSIBILITY

Is the patient under the age of 18? ☐ Y ☐ N *(Patients under the age of 18 must have a parent or legal guardian in attendance)*

Person responsible for bill: _____ Relationship to patient: _____

Address: _____ City: _____ ST: _____ Zip: _____

Cell phone #: (_____) _____ - _____ Home #: (_____) _____-_____ Email:_____

PRIMARY INSURANCE

Policy holder *(Name)*: _____ Date of birth: _____/_____/_____ SSN: _____/_____/_____

Employer: _____ Insurance carrier: _____

SECONDARY INSURANCE

Policy holder *(Name)*: _____ Date of birth: _____/_____/_____ SSN: _____/_____/_____

Employer: _____ Insurance carrier: _____

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of or offering of the Notice of Privacy Practices. I understand how Tri-State Orthopaedic Surgeons, Inc. (TSOS) may use my personal health information and my rights regarding managing this information.

CONSENT FOR TREATMENT: I authorize and consent to an examination by healthcare providers involved in my care at TSOS. If treatment is deemed necessary, I will be provided with the risks, benefits, and alternatives and given the opportunity to ask questions.

My signature below certifies that the information provided on and in connection with this form is true and accurate. I have read and understand the Notice of Privacy Practices and Consent for Treatment. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

_____ ____/____/_____
Patient/Parent or Guardian Signature Date