

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DOB: \_\_\_\_\_ SEX: \_\_\_\_\_ SSN: \_\_\_\_\_ RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

PREFERRED LANGUAGE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
*(Provide your e-mail address to receive our newsletter and other educational topics)*

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

DATE OF INJURY/CONDITION: \_\_\_\_\_ AREA OF BODY INJURED/ CONDITION: \_\_\_\_\_

DO YOU HAVE X-RAYS? \_\_\_\_\_ IF YES, WHERE WERE THESE DONE? \_\_\_\_\_

HOW INJURY/CONDITION OCCURRED : \_\_\_\_\_

\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ (please provide first and last name) REFERRING PHYSICIAN: \_\_\_\_\_ (please provide first and last name)

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER NAME: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

POLICY ID: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

**WORK COMP (ONLY COMPLETE IF YOU HAVE A WORK-RELATED INJURY)**

CARRIER NAME/ EMPLOYER NAME: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CASE MANAGER: \_\_\_\_\_

**RELEASE OF PROTECTED HEALTH INFORMATION**

Under the Federal HIPAA Privacy Rule, HROSM is not allowed to release specific patient information to other individuals or companies without authorization from the patient. This may include appointment and billing information as well as treatment information or copies of your medical records. If you wish to have your information released to individuals or companies (i.e. family members, physicians, attorneys, disability companies) please list these individuals below:

I authorize HROSM to release certain medical information about me to the following individuals or companies:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

I authorize:  Any/all information requested by the above parties (OR)  Specific information as listed below: \_\_\_\_\_

\_\_\_\_\_

For more information regarding HIPAA regulations, I understand that I may request a copy of the Notice of Privacy Practices Form.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_