PATIENT INFORMATION

NAME: _____ DOB: _____ GENDER: _____

SSN: _____ ETHNICITY (check one): ☐ Not hispanic/latino ☐ Hispanic/Latino ☐ Decline RACE: _____

PREFERRED NAME: _____ EMAIL ADDRESS: _____

(Provide your e-mail address to receive our newsletter and patient portal invitation)

PREFERRED LANGUAGE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

FAMILY PHYSICIAN: _____ PHONE No: _____

(please provide first and last name)

REFERRING PHYSICIAN: _____ PHONE No: _____

(please provide first and last name)

DATE OF INJURY/CONDITION: _____ AREA OF BODY INJURED/ CONDITION: _____

HOW INJURY/CONDITION OCCURRED : _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SSN: _____ DOB: _____ SSN: _____ DOB: _____

POLICY ID: _____ POLICY ID: _____

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:
Please note Full PHI will include any and all information: (including personal, health, demographics, claims, billing and medical records

NAME: _____ ☐ Full PHI ☐ Partial PHI

NAME: _____ ☐ Full PHI ☐ Partial PHI

NAME: _____ ☐ Full PHI ☐ Partial PHI

If Partial Information is checked please list the type of information you would like to share in the section below (such as specific treatments, dates of service or billing details):

_____

_____

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

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____