## PATIENT INFORMATION

NAME: ______________________ DOB: ____________ SEX: ____________

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: ____________

SUBSCRIBER NAME: ____________

SSN: ____________ DOB: ____________

POLICY ID: ____________

SECONDARY INSURANCE: ____________

SUBSCRIBER NAME: ____________

SSN: ____________ DOB: ____________

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: ______________________