

# DATA SHEET

OFFICE USE ONLY

Account Number
_____

Have you ever been seen by any of our physicians in the past?

Yes     No

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Maiden Name \_\_\_\_\_  
First MI Last

Responsible Party (If Patient Is a Minor) \_\_\_\_\_

Street and/or P.O. Box Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_

Age \_\_\_\_\_ Patient's Birth Date \_\_\_\_\_

Marital Status (circle one):    Single    Married    Divorced    Separated    Widowed

Name of Nearest Friend/Relative Not Living With You \_\_\_\_\_ Phone No. \_\_\_\_\_

Referring Source (if any) \_\_\_\_\_ Family Doctor \_\_\_\_\_

Patient's Employer (if minor, guardian's) \_\_\_\_\_

Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

If Accident, Give Date of Accident \_\_\_\_\_

Were You Injured on the Job?     Yes     No

Medicare Policy No. \_\_\_\_\_ Medicaid Policy No. \_\_\_\_\_

Primary Insurance (Other Than Medicare) \_\_\_\_\_

Street and/or P.O. Box Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Street and/or P.O. Box Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

*I acknowledge that Hastings Orthopaedics & Sport Medicine Specialists has presented and made available to me their "Notice of Privacy Practices" for protected health information.*

*I authorize Hastings Orthopaedics & Sports Medicine Specialists to use and disclose my Protected Health Information for treatment, payment and healthcare operations. I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that this authorization will remain in effect as long as my dependent or I remain a patient.*

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.*

X \_\_\_\_\_  
Signature of Patient or Patient/Guardian