

ORTHOPEDIC HEALTHCARE ASSOCIATES, INC.

Date: _____
 Name: _____ SS# _____
 Mailing Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Sex: M F Age: _____ Date Of Birth: ____/____/____ Race: _____ Marital Status: M S W D
 Responsible Party: (if minor) _____
 Referring Doctor: (name & address) _____

Emergency Contact Person: _____ **EmergencyPhone:** _____

EMPLOYMENT INFORMATION:

Employer: _____
 Address: _____
 Business Phone: _____ Occupation: _____
 Spouse Name: _____ Spouse Employer: _____ Phone: _____

INSURANCE INFORMATION:

Primary Carrier: _____
 Policy Holder: _____ SS#: _____
 ID#: _____ Policy Holder Date of Birth: ____/____/____ Race: _____
 Secondary Carrier: _____
 Policy Holder: _____ SS#: _____
 ID# _____ Policy Holder DateBirth: ____/____/____ Race: _____

I authorize Dr. Majestro or Dr. Molina to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes. By giving my authorization to leave messages on an answering machine, voicemail, cellular phone, or e-mail. I take full responsibility if someone other than myself retrieves the information.

	PHONE#	YES	NO	N/A
HOME TELEPHONE				
ANSWERING MACHINE				
WORK TELEPHONE				
VOICEMAIL				
CELLULAR PHONE				
PAGER				

E-MAIL ADDRESS: _____

List any persons other than yourself to whom we can release information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your signature indicates your authorization and understanding of this activity.

 Name (printed) Signature Date

The authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.