Date ___ / ___ / _____

Seacoast Orthopedic Associates

New/Annual Patient Information Sheet

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

☐I give permission for detailed messages to be left on my voicemail on the phone number (s) listed above.

Preferred Language for healthcare: _____ Email Address: _____

Primary Care Physician: _____ Chief complaint: _____ ☐Right ☐Left

Date of accident: _____ ☐Work ☐Auto If work related; employer name:_____

New Patients only, how did you hear about us: ☐Family/Friend ☐PCP ☐Google ☐Other: _____

If I have a medical emergency while at Seacoast Orthopedics, please contact:

Name: _____ Phone#: _____ Relationship: _____

HIPAA Privacy Authorization: ☐Do not discuss my medical record with anyone OR

Person who is authorized to contact Seacoast Orthopedics on my behalf (spouse/domestic partner, sibling, caretaker etc) Name: _____ Relationship: _____

Regarding: (**Please check all that apply**) ☐Appointments ☐Billing Questions ☐Medical Records

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I consent to have Seacoast Orthopedic Associates Physicians, mid-level providers and other staff members under the direction of the physicians treat me. Treatment may include Physical Examination, Diagnostic Procedures and Prescription of Medications. I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of Medical Benefits for myself to Seacoast Orthopedic Associates. I authorize payment of medical benefits for myself to Seacoast Orthopedic Associates and authorize the release of any medical information necessary to process this claim. I have read this form or have had it read to me. I further acknowledge to have been made aware of the Notice of Privacy Policy.

Patient/Legal Guardian Signature: _____ Date: ___/___/_____