



**Hess Orthopaedics and Sports Medicine, PLC**  
**Patient Demographic and Information Form**

THIS INFORMATION IS SHARED ONLY FOR TREATMENT, PAYMENT OR OPERATION ACCORDING TO HIPAA LEGISLATION.  
 PLEASE DO NOT LEAVE ANYTHING BLANK ON THIS FORM.

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER:  MALE  FEMALE

SOCIAL SECURITY NUMBER: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  OTHER: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHARMACY OF CHOICE: \_\_\_\_\_  
 (for purposes of electronic prescribing)

**MEDICAL AND PERSONAL INFORMATION: (PLEASE PROVIDE YOUR PERMANENT ADDRESS)**

HOME ADDRESS, CITY STATE, ZIP CODE: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT): \_\_\_\_\_  N/A

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

PREFERRED METHOD OF COMMUNICATION: *circle one:* HOME WORK CELL

MAY WE LEAVE A MESSAGE FOR YOU ON YOUR ANSWERING MACHINE?  YES  NO initial: \_\_\_\_\_

**INSURANCE INFORMATION**

CHOOSE IF APPLICABLE:  PRIVATE INSURANCE  SELF-PAY  WORKERS COMPENSATION

PRIMARY INSURANCE NAME: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_ GROUP ID: \_\_\_\_\_

PRIMARY INSURANCE ADDRESS: \_\_\_\_\_  
 (this address may be located on the back of your insurance card)

POLICY HOLDER'S NAME: \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

SECONDARY INSURANCE:  N/A

SECONDARY INSURANCE NAME: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_ GROUP ID: \_\_\_\_\_

SECONDARY INSURANCE ADDRESS: \_\_\_\_\_  
 (this address may be located on the back of your insurance card)

POLICY HOLDER'S NAME: \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

**Non-Covered Services:** I understand that the service(s) being provided may be non-covered by my health insurance plan, and that I may be responsible for the entire amount billed for services rendered at Hess Orthopaedics and Sports Medicine, PLC and agree to pay for the same. I further understand that payment on charges incurred is due at the time of service or according to the office payment policy, unless other financial arrangements have been made with our business office prior to treatment. I agree to pay all reasonable attorney fees and collections costs in the event of default of payment. I authorize and request that insurance payments be made directly to Hess Orthopaedics and Sports Medicine, PLC should they elect to receive such payment. **PATIENT SIGNATURE:** \_\_\_\_\_

I authorize Hess Orthopaedics and Sports Medicine, PLC to release medical information regarding the above-named patient to: (Only the names listed below will be able to obtain medical information about you. This includes your spouse, children, trainer, coach, etc.).

NAME: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
NAME: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

We will contact the person(s) below in an emergency or if we cannot contact you. If the patient is a minor, please include the name of a legal guardian.

EMERGENCY NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

I consent to treatment necessary for the medical care of the above-named patient. I authorize the release of any or all medical records to the referring or family physician(s), to any health care provider the above-named patient may have referred to, and to the insurance company or third party payor indicated above and/or noted in the patient's chart (if applicable). I understand that, unless I/patient specifically state otherwise, this may include information relating to HIV testing, substance abuse and psychological disorders that may be included in the medical records. I acknowledge that information authorized to any entity, other than a health care provider or health plan, may no longer be protected by the Federal privacy law. I understand that this authorization may be revoked in writing by me/the patient at any time, except to the extent that action has been taken in reliance to this authorization. Unless revoked, I confirm that this authorization will be in effect as long as the patient is under care at Hess Orthopaedics and Sports Medicine, PLC, unless I/patient indicate otherwise. Fax transmittal of medical records is allowed, if indicated.

**PATIENT INITIAL:** \_\_\_\_\_

**PRIVACY POLICY**

I have been offered the privacy policy.  YES, or ask for a copy if desired.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_