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:___/___/_____
Secondary Carrier:_____
Policy Holder:_____SS#:_____
ID#_____Policy Holder DateBirth:___/___/_____

I authorize Drs. Majestro, Molina, Ede, 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.