Date ___ / ___ / _____

Seacoast Orthopedic Associates

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.

How did you hear about us: ☐Family/Friend ☐PCP ☐Google ☐Other: ____________

Preferred Language for healthcare: ______________ Email Address: ____________________________

Primary Care Physician: _________________________ Chief complaint: _____________ ☐Right ☐Left

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

I hereby grant permission for Seacoast Orthopedic Associates to verbally discuss my personal health information to the following individual (s) named below.

Name: _________________________ Relationship: _______________ Phone number: ______________

Regarding: (**Please check all that apply**)

- ☐Appointments: Ability to make, change or cancel appointments on my behalf
- ☐Billing Questions/payments
- ☐Medical Records: Including but not limited to: office visits, MRI reports, lab work
- ☐**Do not discuss my medical record with anyone**

I understand that this authorization is in place until I revoke it by notifying Seacoast Orthopedics in writing.

Emergency Contact: ☐__________Check and initial here if same as above

Name: ________________________ Relationship: ________________ Phone number: ______________

****Please note the Emergency Contact will *not* have access to your appointments, medical records, or billing****

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: ___/___/_____

Please return to the desk once completed in order to be checked in for your appointment.