BROC
BATON ROUGE ORTHOPAEDIC CLINIC

PATIENT INFORMATION SHEET

PATIENT INFORMATION (PLEASE PRINT)

Name _____ Preferred Name _____
Last First Middle

Date of Birth _____ Sex: Male Female Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Email _____

Primary Care Provider _____ Location _____ Office Phone _____

Emergency Contact ****If patient is a minor, list a person to contact regarding medical information.***

Name _____ Phone Number _____ Relationship _____

Employment Status: (circle one) Self Employed Student Full-Time Student Part-Time Unknown
Disabled Full Time Part Time Not Employed On Active Military Duty Retired

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status: (circle one)
Married Divorced
Widowed Single
Unknown Other

Language: (circle one)
English
Spanish
Other _____

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

Hearing Impaired Patients - Interpreter Needed: (circle one) Yes No

RESPONSIBLE PARTY INFORMATION (GUARANTOR)

☐ The Responsible Party (Guarantor) for the account is the same as the patient above.

Complete the following if the patient is under 18 years of age and/or the Responsible Party is someone other than the patient.

Name _____ Preferred Name _____
Last First Middle

Date of Birth _____ Sex: Male Female Social Security # _____

Mailing Address _____ City _____ State _____ ZIP _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Relationship to Patient _____

Employment Status: Self Employed Student Full-Time Student Part-Time Unknown
(circle one) Disabled Full Time Part Time Not Employed On Active Military Duty Retired

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION (PLEASE CIRCLE)

None | Self | Commercial | Medicare | Worker's Comp | Attorney Responsible | Other

(PRIMARY COVERAGE)

Insurance Company _____

Member ID # _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____ Group # _____

Covered Through: (circle one) Current Employer Retirement
Cobra/Continuation of Benefits
Other _____

(SECONDARY/SUPPLEMENTAL COVERAGE)

Insurance Company _____

Member ID # _____

Subscriber Name _____

Relationship to Patient _____

Effective Date _____ Group # _____

Covered Through: (circle one) Current Employer Retirement
Cobra/Continuation of Benefits
Other _____

WORKMAN'S COMP INFORMATION **IF APPLICABLE*

Workman's Comp Carrier _____ Claim # _____

Adjuster _____ Phone _____

Employer _____ Phone _____

ATTORNEY RESPONSIBLE **IF APPLICABLE*

Attorney's Name _____ Phone _____

Acknowledgement of receipt and signature via MYCHART, Electronically or Hard Copy: (Please initial each)

By initialing each item below and providing my signature and date at the bottom of this form, I acknowledge and agree to the following:

Consent to Treatment

_____ I consent to and authorize treatment by Baton Rouge Orthopaedic Clinic.

HIPAA Acknowledgement

_____ I acknowledge that I have received a copy of the 'Notice of Privacy Practices'.

Authorization and Assignment

_____ I authorize Baton Rouge Orthopaedic Clinic to release medical information as needed to submit and process insurance claims for reimbursement. I also assign claim payments, including major medical benefits, to be made directly to Baton Rouge Orthopaedic Clinic. I understand that any overpayment will be refunded to me upon request, regardless of insurance. This authorization and assignment may be revoked by providing written notice at any time.

Financial Responsibility

_____ I acknowledge that I am responsible for paying co-payments and deductibles at the time of service, as well as any amounts not covered by insurance.

Notifications

_____ I consent to receive automated calls, text messages, and email notifications at the contact number and email address I have provided for appointment reminders and other notifications.

Signature _____ Date _____