PEACHTREE ORTHOPEDICS

Release of Information - New Patient Form

Print Name:_____

DOB:_____

Patient Contact Information:

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Do we have your consent to call? Yes/No

Do we have your consent to text? Yes/No

Marital Status: (Circle one)

Married

Single

Divorced

Seperated

Widowed

Partnered

Ethnicity: (Circle one)

Hispanic

Non-Hispanic

Race:_____

Language:_____

Email:_____

Emergency Contact: Name_____ **Relationship**_____**Phone Number**_____

Primary Care Physician/Referring Provider (First & Last Name)_____

Did your Primary Care Physician refer you to our practice? Yes / No

Pharmacy Name & Street Address/Phone:_____

How did you hear about us?_____

Patient Health Information - Release Authorization

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want someone (other than yourself) to pick up documents, x-rays or other items on your behalf.

Please list the name(s) of any individual(s) that you would like to access or retrieve personal health information, documents or other items on your behalf.

1. _____ Relation: _____

2. _____ Relation: _____

☐ I decline to have anyone pick up patient information on my behalf.

Medication History

I understand and agree that Peachtree Orthopedic may request, obtain, access and use my prescription medication history in written or electronic form (including third-party databases) from healthcare providers and/or pharmacy benefit payors for treatment purposes, and that Peachtree Orthopedic may provide and transmit my prescription medication history .

_____ _____

Signature of Patient or Legal Representative Date

☐ I decline to have Peachtree Orthopedic download my medication history as a part of my electronic chart

By signing below, I acknowledge the following two statements:

1. I understand that authorizing the disclosure of this health information is voluntary and I can decline to authorize anyone to obtain my Protected Health Information (PHI). Any other use of this information without my written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

2. I have read and agreed to the HIPAA, Financial, Disability/Medication policies and WC Consents:

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Peachtree Orthopedic Representative/Patient Witness Date

_____ _____

Relationship of Patient Witness Date