IOWA ORTHO
A CENTER OF EXCELLENCE®

Patient Information Form

Doctor:	MRN:	IOC Staff Initials:

Today's Date: _____

Patient Name: _____
Last First Middle Initial Previous Last Nickname

SSN: _____-_____-_____ Date of Birth: ____/____/_____ ❑ Male ❑ Female

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Race: _____ Preferred Language: _____ Marital Status: _____

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown ❑ Declined to Specify

College Student? ❑FT ❑PT ❑NA Is today's visit due to a Sports Injury? ❑Yes ❑No

Who is your Primary Care Physician? (First and Last Name): _____

Which Physician referred you to us? (First and Last Name): _____

HOW CAN WE REACH YOU?

	Contact Choice	Voicemail
Home Phone: _____	1st 2nd 3rd	Y / N
Day Phone: _____	1st 2nd 3rd	Y / N
Cell Phone: _____	1st 2nd 3rd	Y / N
Personal Fax: _____		
Email: _____		

Circle Additional Contact Options

Yes / No - I give my permission to leave messages and/or results on an answering machine (Medical information will not be left on an unidentified answering machine)

Yes / No - I give permission to fax or email my Protected Health Information to the Fax or Email listed on this form. (I understand Protected Health Information sent electronically is not secure).

For Minor Patients Only, List the Primary Contact and Parent or Guardian Information.

Primary Contact: _____ Relationship: _____

Address: _____ Date of Birth: ____/____/_____

Phone: _____ Email: _____

Secondary Contact: _____ Relationship: _____

Address: _____ Date of Birth: ____/____/_____

Phone: _____ Email: _____

RELEASE OF INFORMATION/EMERGENCY CONTACT:

Iowa Ortho will release information about you, based on your selection(s) below. Please specify how your information should be released by selecting the applicable box. This form of communication will be used as the standard until revoked in writing by the patient or we have an updated form on file. If the patient is a minor, this form must be completed and signed by a parent or guardian.

	CONTACT NAME	PHONE	RELATION	MEDICAL INFORMATION	FINANCIAL INFORMATION
1.	_____	_____	_____	❑	❑
2.	_____	_____	_____	❑	❑
3.	_____	_____	_____	❑	❑

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Patient Information Form

Doctor:	MRN:	IOC Staff Initials:

Today's Date: _____

Patient Name: _____
Last First Middle Initial

Employer Name: _____ Employer Phone:_____

Occupation: _____ ❑ Disabled ❑ Retired ❑ Unemployed

If you are currently in a Skilled Nursing Facility or Nursing Home, complete the following:

Location Name: _____ City: _____ Phone: _____

CONDITION, ACCIDENT OR INJURY INFORMATION:

List the approximate date your Condition, Accident or Injury occurred or began: _____/_____/_____

Is this a Chronic problem? ❑ Yes ❑ No If No, indicate where your Accident, Injury or Condition occurred?

❑ Gym ❑ Home ❑ School ❑ Sports Injury ❑ Vehicle ❑ Work Injury

❑ Other (Please List): _____

If a Work Injury, did you report this injury to your employer? ❑ Yes ❑ No Date Notified: ____/____/_____

How did the Accident/Injury or Condition occur? _____

_____

INSURANCE INFORMATION

Primary Insurance: _____

Card Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: ___/___/_____ SSN: _____ Employer: _____

Identification #: _____ Group #: _____ Co-pay/Co-Insurance: _____

Secondary Insurance: _____ Supplement Insurance? ❑ Yes ❑ No

Card Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: ___/___/_____ SSN: _____ Employer: _____

Identification #: _____ Group #: _____ Co-pay/Co-Insurance: _____

I hereby authorize you to release all information necessary to secure payment of said benefits. I understand that it is my responsibility that all incurred charges are paid. I further understand that if I want you to file my insurance, I must provide you with necessary numbers and completed forms, including making a copy of insurance ID card(s).

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and other health plans, to Iowa Orthopaedic Center, P.C. (IOC). A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the original date signed.

My signature below indicates that I have been provided a copy of the Iowa Orthopaedic Center, P.C. Patient Financial Policy and that I thoroughly understand the policy. I understand that you will file my Work Comp Insurance to my personal Insurance if Work Comp has declined it. **I understand that I am financially responsible for all charges incurred, whether or not paid by said insurance.**

My signature below acknowledges that a copy of the Iowa Orthopaedic Center, P.C. NOTICE OF PRIVACY PRACTICES has been made available to me.

Patient or Guardian Signature: _____ Date: _____