

Capital City Orthopaedics
and Sports Medicine

Personal Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Birthdate _____ Age _____ Sex: M F Marital Status: S M W D
Home Phone _____ Cell Phone _____
Email Address _____
Employer _____ Social Security Number _____
Employer's Address _____ Employer's Phone _____
Spouse's Name _____ Spouse's Soc. Sec. # _____
Spouse's Employer _____ Phone _____
Name and Address of Responsible Party (if different from patient) _____

Phone _____
Emergency Contact (Name and Phone Number) _____

Height _____ Weight _____
R or L Handed? _____
Children: Ages if Under 21 _____

Were you referred? _____ Doctor _____ Hospital _____

Business Matters

If the Physician is a Provider for your insurance company, all charges will be filed with that company. Co-Payment is due at time of service. If you do not have insurance coverage, full payment is due at time of service.

Payment will be made by: Cash Check Charge

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. No information will be released without your signed consent.

The signature below authorizes Capital City Orthopaedic and Sports Medicine to release any medical information necessary regarding your medical treatment with this office and authorizes your insurance company to make direct payment to Capital City Orthopaedic and Sports Medicine of any benefits due.

Signature of Patient (or Parent if Minor)

Date