



HIPAA Authorization Release Form

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):

Relationship:

_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- My complete health record, as above, with the exception of the following information: (Check as appropriate):
 - Mental health records
 - Communicable diseases)including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify) _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reason.

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____
unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

Printed Name of Individual Giving this Authorization

Signature of the Individual Giving this Authorization

Date

MINOR REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____
First
Middle
Last

DOB: _____ **Age:** _____ **Sex: Male Female** **SS#:** _____
Month/Day/Year
(Circle One)

PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

Name: _____ **SS #:** _____
First
Middle
Last

DOB: _____ **Relationship to Patient:** _____

Address: _____
Street (If P.O. Box, please also list street number)
Apt.
City
State
Zip

Mobile Phone: (____) _____ **Home Phone:** (____) _____

Employed By: _____ **Work Phone:** (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name: _____
Policy Holder: _____
SS #: _____ **DOB:** _____
Group #: _____ **Policy #:** _____

SECONDARY INSURANCE

Ins. Co. Name: _____
Policy Holder: _____
SS #: _____ **DOB:** _____
Group #: _____ **Policy #:** _____

We need your authorization in order to file insurance, speak with or release written information to anyone about your condition. If there is anyone (such as spouse, parent, attorney, etc.) that will be calling on your behalf for any reason, please list them below.

Name(s) of person(s) and/or insurance company(ies) authorized for release of information

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received a company of this medical practice's Notice of Privacy Practices.

I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions _____

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

ORTHO PATIENT MEDICAL FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First *Last*

CURRENT MEDICAL HISTORY (check all of the medical symptoms that you are currently experiencing):

Constitutional:

Fatigue

Fever

HEENT:

Hoarseness

Nose Bleed

Cardiology:

Chest Pain

Shortness of breath

Swelling of ankles

Neurology

Headache

Loss of feeling in legs

Numbness

Seizures

Respiratory

Blood-tinged sputum

Cough

Wheezing

Gastroenterology

Abdominal pain

Black stools

Blood in stools

Heartburn

Nausea

Hematology/Lymph

Abnormal bleeding

Musculoskeletal

Bone pain

Joint stiffness

Joint pain

Joint swelling

Joint redness

Leg cramps

Muscle pain

Muscle stiffness

Psychology:

Depression

Urology:

Blood in urine

Recurrent UTI

Dermatology:

Rash



PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____
First Middle Last

DOB: _____ **Age:** _____ **Sex:** Male Female **SS#:** _____ - _____ - _____
Month/Day/Year

Email: _____ **Cell Phone #:** (_____) _____

Address: _____
(If P.O. Box, please also list street number) City State Zip

Employer: _____ **Work Phone:** (_____) _____

PARENT/GUARDIAN OR SPOUSE RESPONSIBLE FOR BILL

Name: _____ **SS #:** _____ - _____ - _____ **DOB:** _____
First Middle Last

Relationship to Patient: _____ **Cell Phone#:** (_____) _____ **Alternate Phone:** (_____) _____

Address: _____
(If P.O. Box, please also list street number) City State Zip

Employer: _____ **Work Phone:** (_____) _____

IN CASE OF EMERGENCY

Emergency contact person outside your home: _____

Relationship to Patient: _____ **Phone:** (_____) _____

Address _____
Street City State Zip

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins. Co. Name: _____	Ins. Co. Name: _____
Policy Holder: _____	Policy Holder: _____
SS #: _____ DOB: _____	SS #: _____ DOB: _____
Group #: _____ Policy #: _____	Group #: _____ Policy #: _____
Policy Holder's Relationship to Patient: _____	Policy Holder's Relationship to Patient: _____

The information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also know as Acquired Immune Deficiency Syndrome or AIDS. I further authorize the insurance company listed above to make payment directly to Orthopaedic Sports Medicine Center-Norman, P.C. for services regarding this illness or injury. I understand that I am financially responsible for payment of all charges. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of an amended Notice of Privacy Practices at each appointment.

Requested Restrictions _____

Print Name: _____ **Relationship to Patient:** _____

Patient's Signature (or parent/guardian if minor): _____ **Date:** _____

PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient's Name: _____ **DOB:** _____

First
Last

List All Medications that you are currently taking:

<i>Medication</i>	<i>Strength</i>	<i>Quantity</i>	<i>Frequency</i>

List any medication allergies: N/A _____

List all past surgeries:

<i>Surgery</i>	<i>Year</i>

List all hospitalizations:

<i>Reason for hospitalization</i>	<i>Year</i>

Patient's Name: _____ DOB: _____
First Last

FAMILY HISTORY

Number of Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Check the box for those medical histories that apply:

Member	Status	YOB	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								
Sibling	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased								

SOCIAL HISTORY

Do you smoke? No Yes Approximate number per day: _____

Are you pregnant? N/A No Yes

Marital Status: Single Married Divorced Widowed

Do you drink alcohol? Never Monthly Two to four times a month Two to Three times per month Four or more times per month

Do you exercise regularly? No Yes Times per week: _____

Have you traveled outside the U.S. in the past 10 years? No Yes

Have you ever used recreational drugs? No Yes

PAST MEDICAL HISTORY (check all medical conditions that apply):

- | | | | |
|--------------------|--------------------------|---------------------|--------------------------|
| Acid reflux | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> |
| Seasonal Allergies | <input type="checkbox"/> | Gout | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | HIV | <input type="checkbox"/> |
| Blood Clot | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> |