NORTHWEST ORTHOPAEDIC SPECIALISTS

NWOrthopaedicSpecialists.com

Date: _____

New Patient Form

New Patient Information:

Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
☐ Male ☐ Female Date of Birth: _____
Social Security No.: _____
Email Address: _____

Required by government mandate (although you may refuse)
Language.: _____
Race: _____
Ethnicity: _____
Marital Status: _____

Other:

Patient Referred By: _____
Primary Care Provider: _____
Contact Preference: ☐ Home Phone ☐ Work Phone
☐ Cell Phone ☐ Portal ☐ Email

Primary Insurance Information:

Insurance Plan Name: _____
Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Employer Name: _____
Patient's relationship to policy holder: _____

Guarantor Information (to whom statements are sent):

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Phone: _____
Date of Birth: _____
Social Security No.: _____

Emergency Contact Information:

Name: _____
Relationship to Patient: _____
Phone: _____
Cell Phone: _____

Employer Information:

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

Pharmacy Information:

Name: _____
Cross streets: _____
Phone: _____

Secondary Insurance Information:

Insurance Plan Name: _____
Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Employer Name: _____
Patient's relationship to policy holder: _____

Worker's Comp or Motor Vehicle Accident Information:

Worker's Comp Plan Name: _____
Plan Full Address: _____
Claim Number: _____
Date of Injury: _____

To the best of my knowledge, the above information is complete and accurate.

X _____

Signature of Authorized Person Date Relation

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Patient Name (Please Print) _____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

• I have read and understand the HIPAA/Privacy Policy for **Northwest Orthpaedic Specialists PS**

Signed: _____ Date: _____

• I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed: _____ Date: _____

• I authorize **Northwest Orthpaedic Specialists PS** to release medical information required to process my claim

Signed: _____ Date: _____

• I have read and understand the Financial Policy for **Northwest Orthpaedic Specialists PS**

Signed: _____ Date: _____

• I authorize **Northwest Orthpaedic Specialists PS** to obtain/have access to my medication history

Signed: _____ Date: _____

• I authorize my provider's office to contact me by mobile phone

Signed: _____ Date: _____

Northwest Orthopaedic Specialists, P.S., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.