



A History of Excellence

Acct. # \_\_\_\_\_ Dr. # \_\_\_\_\_ Recep. \_\_\_\_\_

We are appreciative of the individuals and companies that continue to refer to our practice. How did you hear about our practice?

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Home Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Information: Gender:  M  F SS #: \_\_\_\_\_

DOB: \_\_\_\_\_  Widowed  Single  Married  Other: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

Race:  Asian  Black/African American  Native American  White  Unknown  Other \_\_\_\_\_  Prefer Not to Answer

Ethnicity:  Hispanic  Non Hispanic  Unknown  Other \_\_\_\_\_  Prefer Not to Answer

Language:  English  Spanish  Other \_\_\_\_\_

Military Veteran:  Yes  No

PLEASE PROVIDE INSURANCE CARDS FOR US TO COPY

Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child \_\_\_\_\_  Other \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's name \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child \_\_\_\_\_  Other \_\_\_\_\_

Third/Other Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group #: \_\_\_\_\_

\*HIPAA: I hereby acknowledge that St. Louis Orthopedic Institute, Inc has offered me a copy of it's HIPAA Notice of Privacy Practices \_\_\_\_\_ (Initial) Please visit our website at www.stloi.com to read our Privacy Notice or ask our front desk staff.

I hereby agree that St. Louis Orthopedic Institute may disclose my Private Health Information to : \_\_\_\_\_ , an individual involved with my care as a spouse, family member, etc.

X \_\_\_\_\_

Patient Signature or (Individual Authorized Representative)

Date

If you are a personal representative signing this Acknowledgement please provide a description of your relationship: \_\_\_\_\_

Power of Attorney : yes or no (circle)

St. Louis Orthopedic Institute, Inc. does not discriminate against Race, Color, Religion, National Origin, Ancestry, Sex or handicap. I understand I am responsible for obtaining all precertification required by my insurance company. I authorize the release of information to my insurance company, including Medicare, and my attending physician. I hereby authorize my insurance benefits to be paid directly to St. Louis Orthopedic Institute. If signed by guardian or parent for this patient, this is the authorization for medical treatment of a minor.