GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____ **Birthdate**_____-____-_____ **Age**_____

Sex: M☐ F☐ Social Security #_____-_____-_____

Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Address_____ City_____State PA Zip_____

Email Address_____ Marital Status: S☐ M☐ D☐ W☐

Emergency Contact _____Relationship _____Phone (_____) _____-_____

Pharmacy Name/Location_____ Phone (_____)_____-_____

Primary Care Physician _____ Phone (_____) _____-_____

Address _____

Referring Physician Name_____ Phone (_____) _____-_____

Parent or legal guardian (If patient is under age 18) *please print*

Parent/Legal guardian's Name_____ Birthdate _____-_____-_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Social Security #_____-_____-_____

Parent or legal guardian's signature_____ Date_____

(Federal Regulations Requirement) *This is a 3 part question*

1) **Ethnicity**: Hispanic /Latino☐ Not Hispanic /Latino☐ Decline☐
2) **Race:** Asian☐ White☐ Black☐ Other_____or Decline☐
3) **Preferred Language:** English☐ Spanish☐ Other_____

With my signature, I confirm the information provided on this page is complete and accurate.

Signature_____Date_____

HIPAA

Acknowledgement of receipt of Greater Pittsburgh Orthopaedic Associates Notice of Privacy Practices:

Signature_____Date_____

GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____ **Birthdate**_____-____-_____ **Age**_____

Primary Insurance (Please present card for verification)
Insurance Name_____Specialist Co-payment$_____

Insurance ID #_____Group #_____Effective date_____-_____-_____

Address_____ City_____State---_____Zip_____

Subscriber Name_____ Sex: ☐M ☐F Birthdate_____-_____-_____

Social Security #_____Subscriber Address_____

Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Relationship to patient_____

Secondary Insurance (Please present card for verification)
Insurance Name_____Specialist Co-payment$_____

Insurance ID #_____Group #_____Effective date_____-_____-_____

Address_____ City_____State---_____Zip_____

Subscriber Name_____ Sex: ☐M ☐F Birthdate_____-_____-_____

Social Security #_____Subscriber Address_____

Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Relationship to patient_____

Auto/Workers Compensation Claims Injury Description _____

Accident Date/ Injury Date _____Type of Claim ☐Auto ☐WC

Auto/Workers Comp Claim #_____

Insurance Name_____Phone #_____

Address_____ City_____State---_____Zip_____

Contact Person_____

If workers Comp, Employers name_____Phone #_____

Billing and Payment

I authorize that payment on my behalf be made directly to Greater Pittsburgh Orthopaedic Associates for all covered charges and any service NOT paid by me. I agree to pay Greater Pittsburgh Orthopaedic Associates for all charges that are not covered or are denied by the insurance carrier. We request that you make payment or payment arrangements within 30 days.

I authorize Greater Pittsburgh Orthopaedic Associates and its agents to release routine information pertaining to my evaluation and treatment to their agents, workers compensation insurance carriers (my employer) referral source, primary care physician, a consulting physician or medical facility, spouse, immediate family members or guardian, or myself to aid in my medical management

Signature_____Date_____

The above-signed authorizations are to be considered valid as long as I am under the care of Greater Pittsburgh Orthopedic Associates unless revoked by written request.

GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____ **Birthdate**_____-____-_____ **Age**_____

Height_____ Weight_____ Hand Dominance- Right☐ Left☐ Ambidextrous☐

Why are you seeing the doctor today? _____ Right side ☐ Left side☐

Describe injury/present illness in detail_____

_____

How long has it been bothering you? _____

Current problem is the result of a(n):

Car Accident ☐ Work Accident☐ Accident☐ Other☐ Date of Accident _____

Employer _____ Employer's Address_____

Occupation_____ Full-time☐ Part-time☐

Are you currently working? ☐If no, last day worked_____

Are you taking any herbs or vitamin or diet pills supplements? ☐if yes, describe_____

_____ _____ _____

Do you take aspirin daily?☐

Please list your medication you are currently taking:

Medication Name	**Strength**	**Dosage**	**Frequency**	**Medication Name**	**Strength**	**Dosage**	**Frequency**