

Patient Information			
Full Name: _____ Preferred Name: _____			
Address: _____ City: _____ State: _____ Zip: _____			
Patient Birth Date: ____/____/____ Patient SSN: _____ Marital Status: _____			
Parent of Guardian (Complete if Minor): _____			
Birth Date: ____/____/____ SSN: _____ Primary Care Doctor: _____			
Skilled Nursing Facility Address: _____			
<u>Preferred Language:</u> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<u>Race:</u> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____	<u>Ethnicity:</u> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<u>Preferred Contact:</u> <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____			
Email: _____ Employer: _____			
Pharmacy: _____ Pharmacy Location: _____			
Insurance Information			
Primary Medical Insurance: _____			<u>Insured Party:</u> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Policy Holder Name: _____			
ID Number: _____ Group Number: _____			
Policy Holder's Birth Date: ____/____/____ Policy Holder's SSN: _____			
Secondary Medical Insurance: _____			<u>Insured Party:</u> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Policy Holder Name: _____			
ID Number: _____ Group Number: _____			
Policy Holder's Birth Date: ____/____/____ Policy Holder's SSN: _____			
Information Disclosure to Family Members (Optional)			
I authorize Middle Georgia Orthopaedics to disclose information regarding my medical treatment and health coverage to the following individuals:			
Name: _____ Phone #: _____ Relationship: _____			
Name: _____ Phone #: _____ Relationship: _____			
Name: _____ Phone #: _____ Relationship: _____			
Signature: _____ Date: _____			

PLEASE READ AND SIGN THE BACK

K. Scott Malone, M.D. | William B. Wiley, M.D. | Jeffrey C. Easom, D.O. | Daxes M. Banit, M.D.
Derrick D. Phillips, M.D. | David H. Wiley, M.D. | Jonathan Harris, M.D.

Release of Information

I authorize Middle Georgia Orthopaedics to receive and disclose any non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Notice of Privacy Practices Patient Acknowledgement

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information. I have received, read, and understood the notice of privacy practices. I also understand Middle Georgia Orthopaedics reserves the right to change the terms of its notice of privacy practices at anytime and will provide a current notice of privacy on request.

Assignment of Benefits

I hereby assign Middle Georgia Orthopaedics any insurance or other third party benefits available for health care services provided to me. I understand that Middle Georgia Orthopaedics has the right to refuse or accept assignment of such benefits. I agree to forward to Middle Georgia Orthopaedics all health insurance and other third party payments that I receive for services rendered to me immediately upon request.

Consent for Treatment

I authorize Middle Georgia Orthopaedics and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, indicated.

Financial Policy

I understand that Middle Georgia Orthopaedics has instituted a standard financial policy regarding payment for services rendered at their facilities or in hospital setting by members of the practices. I have received, read, and understood the practice's financial policy and I agree to the terms of the policy. I also understood and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient.

Signature: _____

Printed Name: _____ Date: _____

Middle Georgia Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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