

**\*\*ORTHOPEDIC SPECIALTIES\*\***  
**PATIENT INFORMATION**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Social security #: \_\_\_\_\_ Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical address (if different from above): \_\_\_\_\_  
Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**\*\*RESPONSIBLE PARTY INFORMATION (INSURANCE POLICY HOLDER)\*\***

Name: \_\_\_\_\_ Social security#: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Driver's license#: \_\_\_\_\_  
Home/Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

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**\*\*INSURANCE INFORMATION\*\***

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
Is this visit due to the result of a car accident? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Are you seeing an attorney due to this injury? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
Is this a Workman's Comp. Injury? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Workman's Comp. Insurance carrier: \_\_\_\_\_ Claim#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Adjuster's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*Emergency contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_  
\*Ordering Physician's Name: \_\_\_\_\_

**\*\*PLEASE NOTE, PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.\*\***

I authorize the release of any information required to process this claim. I authorize payment of medical benefits to ORTHOPEDIC SPECIALTIES, for any medical services provided. I understand that I am financially responsible for all services provided (including non covered services of Medicare and/or Medicaid).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ORTHOPEDIC SPECIALTIES, INC.  
2467 S. TELSHOR BLVD.  
LAS CRUCES, NM 88011  
575-522-5773

### Notice of Privacy Practices

I certify that I have been informed of Orthopedic Specialties' Notice of Privacy Practices. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Orthopedic Specialties' health care operations. The notice also describes my right and Orthopedic Specialties' duties with respect to my protected health information. The Notice of Privacy Practices is posted in the front waiting room.

Orthopedic Specialties reserves the right to change the Privacy Practices that are describe in the notice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy to be sent in the mail or asking for one at the time of my appointment.

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

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Witness