NORTHERN
Orthopaedics
a department of Northern Regional Hospital

PATIENT INFORMATION

Last Name	First Name	Middle Name	Date of Birth	Sex
Address	City	State	Zip	Social Security No.
Home phone	Work phone	Cell phone	Email ❑ I decline to provide email address	
Race	Ethnicity	Preferred language		
Who referred you to this office?	Who is your family doctor?	Preferred Pharmacy		
Marital Status	Spouse's Name	Date of Birth	Social Security No.	

EMPLOYER INFORMATION

Patient's Employer	Address	City	State	Zip
Spouse's Employer	Address	Work phone		

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Person to Notify	Address		
Relationship	Home phone	Work phone	Cell phone

FOR CHILDREN ONLY

Father's Name		Mother's Name	
SSN:	Date of Birth	SSN:	Date of Birth
Address (If different that patient)		Address (If different that patient)	
Home phone	Cell phone	Home phone	Cell phone
Father's Employer Name & Phone Number		Mother's Employer Name & Phone Number	

INSURANCE Information (Please allow us to photocopy your insurance cards

Primary Insurance	Seconday Insurance

I hereby authorize NMG−Orthopaedics to treat me as a patient. Additionally, they may release necessary information to my insurance carriers in order to obtain payment for these services. I assign to Northern Hospital of Surry County and/or Surry Regional Health Services all payments for medical services rendered to myself or my dependents. I understand that I am personally responsible for this account and that payment is expected when services are rendered unless other arrangements have been made in advance. Pricing received at checkout is just an estimate of fees. Total fees are determined once billing is complete.

You may be charged a $50.00 fee if you are a "No Show" for a scheduled appointment.

I have been informed of my rights and responsibilities.

_____ _____ _____

Signature of Patient or Patient's Representative & Relationship **Time** **Date**

NORTHERN MEDICAL GROUP
ORTHOPAEDICS
a department of Northern Hospital

ACCIDENT OR ONSET INFORMATION

If NOT an injury, when did your symptoms first occur? _____

DATE OF INJURY _____

Where did the accident happen? _____

Explain in detail how the injury occurred: _____

_____

_____

Is this injury related to an auto accident? ❑ **YES** ❑ **NO**

Is this injury work related? ❑ **YES** ❑ **NO**

If work related, list employer name, address, phone number and contact person:

Employer _____ **Contact Person** _____

Address _____ **Phone Number** _____

Who is responsible for the charges? _____

Patient/Representative Signature _____ **Time** _____ **Date** _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of NMG−Orthopaedics Financial Policy, the "No Show" policy, and the Notice of Privacy Practices.

AUTHORIZATION TO RELEASE PHI TO FAMILY OR OTHER AUTHORIZED REPRESENTATIVES

I authorize the release to or discussion of my protected health information to the following people on my behalf.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

**NOTE: NMG−Orthopaedics may, as allowed by the HIPAA Privacy Rule, release medical information to another treating medical facility without additional written authorization.

_____ _____ _____

Signature of Patient or Patient's Representative & Relationship **Time** **Date**