ORTHOPEDIC ASSOCIATES OF LAKE COUNTY

7551 Fredle Drive • Concord, OH 44077 • Ph 440-350-9595
6550 North Ridge Rd. Suite 201 • Madison, OH 44057 • Ph 440-428-1944

PATIENT INFORMATION

Patient Name	☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W
Street Address	Date of Birth Age
City State Zip	SS #
Home Phone #	**Race** / **Ethnicity** / **Language**
Cell #	☐ Caucasian ☐ Hispanic or Latino ☐ English
E-mail Address	☐ African American ☐ Not Hispanic or Latino ☐ Spanish
Employer Phone #	☐ Hispanic ☐ Other _____
	☐ Other _____

Pharmacy Name **Location** **Phone #**

INSURANCE CARDHOLDER INFORMATION

Name
Date of Birth
SS #
Relationship to Patient
Name of Insurance Plan
ID # Group #

PARENT / GUARDIAN INFORMATION

Name
Street Address
City State Zip
Date of Birth SS #
Phone # Cell #
Relationship to Patient

SECONDARY CARDHOLDER INFORMATION

Name
Date of Birth
SS #
Relationship to Patient
Name of Insurance Plan
ID # Group #

FINANCIAL GUARANTOR

Name
Street Address
City State Zip
Date of Birth SS #
Phone #
Relationship to Patient

EMERGENCY CONTACT

Name Phone #
Relationship

Financially Responsible for Healthcare: ☐ Yes ☐ No

If No, Please list

ACKNOWLEDGMENT RECEIPT OF PRIVACY PRACTICES

I have received Orthopedic Associates of Lake County's Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

⊗ **Signature** **Date**

CONSENT AND RELEASE OF INFORMATION

I, the undersigned, hereby consent to the administration of such medications, testing, and treatment for the above named patient as are considered necessary or advisable by the physician and health personnel. I hereby authorize the release of necessary information to authorized agencies, primary care physicians, employers, and/or insurance companies and further assign any and all applicable insurance benefits to Orthopedic Associates of Lake Co. and personally guarantee payment for services not covered by my insurance. Orthopedic Associates of Lake Co. can use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

⊗ **Signature** **Date**