ORTHOPEDIC SPECIALISTS, S.C
360 W BUTTERFIELD RD
SUITE 160
ELMHURST, IL 60126

Patient Information		
Last Name:	First Name:	M.I:
Mailing Address: (No P.O. Box)	Apt#	
City/State/Zip:		
Home Phone:	Cell Phone:	Email:
Family or Referring Physician:	Date of Birth:	Sex:
Marital Status:	Social Security #:	
Employer Name:	Emergency Contact Name:	
Emergency Contact Phone #:	Relationship to Patient:	

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder’s Date of Birth:	Policy Holder’s Date of Birth:
Policy Holder’s Social Security #:	Policy Holder’s Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Patient Policy #:	Patient Policy #:

AUTHORIZATION: I hereby authorize Orthopedic Specialists, S.C. to release any information contained in my medical record to my insurance company, referring physician, and/or primary care doctor. I also authorize for benefits to be paid directly to Orthopedic Specialists, S.C. for medical services I received from any of the healthcare providers in this practice. I understand that I will be responsible for any unpaid balances, including charges for which a referral was not obtained. If this account goes to collections, I will be liable for collection costs and attorney fees.

SIGNATURE:____DATE:_______________

ORTHOPEDIC SPECIALISTS, S.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I____, have received a copy of the Orthopedic Specialists, S.C. Notice of Privacy Practices

Patients Signature____Date____________

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND FINANCIAL INFORMATION

I understand the person(s) named on this authorization will be given access to obtain or review my records and have my permission to discuss my care or obtain results/information on my behalf. This authorization extends only to the person(s) identified below.

Name	Relationship

☐ I **do not** authorize or disclosure to my spouse, family members or any personal representative at this time.

Patients Signature____Date____________

CONSENT TO TREAT

I hereby give consent to Orthopedic Specialists, S.C. to disclose information contained in my health record for treatment purposes. This includes releasing my records to my referring physician, primary care physician and any other health care providers involved in my medical management, unless specific restrictions are indicated below. I understand Orthopedic Specialists, S.C. may legally decline to accept me as a patient, if I refuse any or all of the consents outlined above. I have been provided with the Privacy Notice that more thoroughly explains my rights.

Patients Signature____ Date__________________

Office staff initials____________________________ Date__________________