Orthopedic Institute of Rio Grande Valley, PA
1203 E. Alton Gloor Blvd.
Brownsville, TX 78526
Phone: 956-544-BONE (2663)
Fax: 956-542-2366

PATIENT REGISTRATION

~~Please print clearly so that we can process your information quickly and efficiently. Thank you!~~

Last Name: ______________________ First Name: _____________________ Middle Name: ________

Suffix: ________________ Sex: Male / Female Date of Birth: __________ SS#: ___________________

Address: __________________________ City: ______________ State: _______ Zip code: ___________

Home Phone#: _________________ Cell Phone#: _____________________ Work#: ________________

Consent of Text: Yes / No Patient e-mail: ____

Contact Preference: (circle one) Home Phone Cell Phone Work Phone Mail Portal

Language: English / Spanish other ____________ Race: __________ Ethnicity: ____________ N/A__

Marital Status: (circle one) Married Single Divorced Separated Widow Life Partner

Home Bound: (circle one) Yes / No (Yes: Able to drive or No: Unable to drive)

How did you hear about us? (circle one) Advertising Physician Word of Mouth Patient in Hospital Insurance Company Other: Please List _____________________________

Primary Care Physician: __________________________ Referring Physician: _____________________

Pharmacy of Choice ________________________________ Location ____________________________

When did injury occur? ______________________________ Is this injury work related? YES / NO

PRIVACY AND BILLING

Consent to receive automated phone calls on mobile devices on appointments/results: YES / NO

Consent to import medication history: YES / NO **CONTINUATION**

Patient Initials: ________________

Guardian (person responsible for medical decisions other than patient)

Last Name: ____________________ First Name: ____________________ Middle Name: ___________

Suffix: __________________ Relationship: __________________________________

Emergency Contact

Name: ______________________________________ Relationship: __________________

Phone #: _______________________________

Employment

Employer Name: _______________________ Employer #: __________________________

Occupation: ________________________________

Guarantor (primary name on insurance)

Last Name: _________________________ First Name: __________________ Middle Initial: _______

Date of Birth: ________________________

Insurance Information

Insurance Company: ____

I hereby assign, transfer, and set over to **Orthopedic Institute of Rio Grande Valley, PA** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. The authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

Patient Signature: __________________________________ Date: ___________________________

Patient Printed Name: _____________________________________

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

**** IF YOU BRING IN X-RAY/ MRI CD AND NEED IT BACK AFTER THE OFFICE VISIT, IT'S PATIENT'S REPONSIBILITY TO ASK FOR IT AFTER VISIT. CD WILL BE DISPOSE AFTER 7 DAYS OF OFFICE VISIT****

Patient's initials: ____________

IF X-RAY WAS TAKEN IN OUR OFFICE AND PATIENT IS REQUESTING A COPY OF
X-RAY THERE WILL BE A $5.00 FEE / IF PATIENT IS REQUESTING COPIES OF MEDICAL RECORDS THERE IS A $25.00 FEE

PATIENT RECORD OF DISCLOSURES

In general, the **HIPPA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Signature: ________________________________ Date: ________________

Print Name: _____________________________________ Date of Birth: _________