TriHealth
Orthopedic & Spine Institute

513.985.3700

PATIENT INFORMATION RECORD
(Please Print or Write Legibly)

TO OUR PATIENTS: All grey box text must be completed to meet the requirements set forth to treat and bill on your behalf. Please complete all areas so that your treatment with Ohio Valley Orthopaedics and Sports Medicine, Inc. can be properly documented and represented on your behalf. We thank you for your cooperation.

PATIENT INFORMATION

PATIENT'S FIRST NAME MIDDLE INITIAL LAST NAME		M ☐ F ☐	☐ Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced
STREET ADDRESS	CITY, STATE ZIP		HOME PHONE NUMBER ( )
BIRTHDATE AGE	SOCIAL SECURITY NUMBER		CELL PHONE NUMBER ( )
EMPLOYER (if aplicable)	ADDRESS, CITY, STATE ZIP		WORK PHONE NUMBER ( )

PERSON RESPONSIBLE FOR BILLS (INSURED/PARENT)

NAME	RELATIONSHIP TO PATIENT	BIRTHDATE OF RESPONSIBLE PARTY
HOME ADDRESS	CITY, STATE ZIP	
HOME PHONE NUMBER (ALTERNATE IF NOT HOME)	WORK #	
PLACE OF EMPLOYMENT OF INSURED	ADDRESS OF EMPLOYER (PLEASE PROVIDE STREET NAME MINIMUM)	

PRIMARY INSURANCE INFORMATION (Private, Medicare, Worker's Compensation)

NAME OF INSURANCE	EFFECTIVE DATE	NAME OF EMPLOYER & STREET LOCATION	GROUP NUMBER
COMPLETE MAILING ADDRESS OF INSURANCE COMPANY IF NOT PROVIDED ON CARD			
SUBSCRIBER'S NAME	I.D. #	SOCIAL SECURITY NUMBER	SUBSCRIBER'S BIRTHDATE

WORK RELATED INJURIES (Please complete all information must be completed for OVOSM to treat you)

WORKER'S COMPENSATION CLAIM#		EMPLOYER AT TIME OF ACCIDENT	ADDRESS AND PHONE NUMBER
ACCIDENT DATE	HAVE YOU NOTIFIED YOUR EMPLOYER OF ACCIDENT? Y N HAVE YOU BEEN TREATED ELSEWHERE FOR THE INJURY? Y N	PROVIDE NAMES AND PHONE NUMBERS OF PREVIOUS PHYSICIANS IF ER/URGENT CARE-PROVIDE NAME & PHONE OR LOCATION THAT TREATED YOU FOR THIS INJURY	

SECONDARY INSURANCE INFORMATION (Private, Medicare, Worker's Compensation)

NAME OF INSURANCE	EFFECTIVE DATE	NAME OF EMPLOYER & STREET LOCATION	GROUP NUMBER
COMPLETE MAILING ADDRESS OF INSURANCE COMPANY IF NOT PROVIDED ON CARD			
SUBSCRIBER'S NAME	I.D. #	SOCIAL SECURITY NUMBER	SUBSCRIBER'S BIRTHDATE

PRIMARY/REFERRING PHYSICIAN INFO

NOTICE : PROVIDING US WITH YOUR REFERRING OR FAMILY PHYSICIAN ALLOWS US TO COMMUNICATE DETAILS ABOUT YOUR CARE. IF YOU DO NOT WISH FOR US TO COMMUNICATE WITH YOUR DOCTOR(S) PLEASE DO NOT COMPLETE THIS SECTION AND MARK BOX WITH YOUR INITIALS ☐	REFERRING PHYSICIAN (IF NONE, PLEASE INDICATE) FIRST AND LAST NAME
	ADDRESS OR PHONE
	FAMILY PHYSICIAN (IF NONE, PLEASE INDICATE) FIRST AND LAST NAME
	ADDRESS OR PHONE

NOTICE OF ASSIGNMENT & DISCLOSURE

I hereby authorize Ohio Valley Orthopaedics & Sports Medicine, Inc. to furnish information to insurance carriers concerning my illness, treatments, and physical therapy, and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance. I understand that I am also responsible for payment if I failed to obtain a referral or follow the rules set by my insurance company. Ohio Valley Orthopaedics has my authorization to disclose my "protected health information" for purposes of payment, treatment, and healthcare operations. A summary of Privacy Policies is displayed in the office and a full manual available at my request.

(Signed) Patient or Guardian (if minor) _____ Relationship to Patient _____ Date _____