SPIVEY
ORTHOPEDIC CLINIC

*Board-Certified, Sports Trained Orthopedic Surgeon * Specializing in General Orthopedics and Sports Medicine*

Basic Patient Demographics

Last Name: _____ First Name: _____
Middle Name: _____ Birthdate: _____ Sex: _____
Preferred Language: _____ Race: _____
Marital Status: _____ Social Security Number: _____ Ethnicity: ☐Non-Hispanic ☐Hispanic

Preferred #:_____ Work #: _____ Cell #: _____
Email Address: _____
(By giving your email address and cell number, you consent to email and text communications from our office.)

Address: Street: _____
City: _____ State: _____ Zip Code: _____
County: _____

Person/Parent Responsible for the account (other than the patient)

Relationship: _____
Last Name: _____ First Name: _____
DOB: _____ SS#: _____ Contact Info Same as Patient: ☐Yes ☐No
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Cell #: _____
Email: _____

Additional Providers

Referring Provider: _____
Primary Care Provider: _____

Insurance Information

PLEASE COMPLETE AND SUPPLY A COPY OF YOUR CARD(S)

Primary Insurance: _____ Policy#: _____
Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SSN: _____ Driver's Lic #: _____
Is this a Medicare Plan? ☐Yes ☐No
Is this a Marketplace Plan? ☐Yes ☐No
Are you under Hospice Care? ☐Yes ☐No
Are you currently a resident in a Nursing Home? ☐Yes ☐No, If Yes, Where? _____

Secondary Insurance: _____ Policy#: _____
Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ SSN: _____ Driver's Lic #: _____

Worker's Compensation Information

☐**NO,** I am NOT here due to a work-related injury.
☐**YES**, I am here for a work injury and have reported this to my employer. My employer has sent the appropriate authorization for treatment. If you choose this option, your medical insurance will NOT be filed.
My Employer Is _____ Phone: _____

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

3301 First Street East, Suite A • Vidalia, Georgia 30474
(912) 537-4411 • Fax (912) 538-8485

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Patient Name: _____ Birthdate: _____

PATIENT HIPAA FORM

I hereby authorize Spivey Orthopedic Clinic to share my personal health information with:

☐ NO ONE other than myself and those required by law.

☐ My Spouse: _____

☐ My Parent(s): _____

☐ My Children: _____

☐ My Friend: _____

☐ Other: _____

_____

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

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