K.L.Vandervoort, MD
D.D.Tippets, MD
G.T.Hardy, MD

Anniston Orthopaedic Associates, P.A

M.R. Wiedmer, MD
D.M.Tippets, DO
A.C. Morris, MD

Patient Information Sheet

Name: _____ **Preferred Name: _____**

Date of Birth: _____ **Gender: _____** **Social Security #_____**

Mailing Address: _____
City State Zip

Home Phone #: _____ **Cell Phone #: _____**

Marital Status: ***Married/Single /Divorced/Partner/Widowed*** **Email: _____**
(Circle One)

Race: ***American Indian or Alaskan Native /Asian/ Black or African American/ Caucasian/ Native Hawaiian or Pacific Islander***
(Circle One)

Ethnicity*: Hispanic or Latino* OR *Not Hispanic or Latino* **Preferred Language: _____**
(Circle One)

Emergency Contact: _____
Name Relationship Phone

Are you currently in a nursing home, rehab facility or long-term care facility? ***Yes*****_____** ***No*** **_____**

If yes, what is the name of the facility? _____

Please complete the following responsible party information if the patient is under the age of 19:

Name of responsible party: _____ **Relationship to patient: _____**

Address: _____ **Phone: _____** **DOB: _____**

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name: _____ **Date of Birth: _____**

Name of Secondary Insurance: _____

Policy Holder Name: _____ **Date of Birth: _____**

Release of Information Sheet

Patient Name: _____ Date of Birth: _____

Any Physician, employee or representative of Anniston Orthopaedic Associates, P.A. has my permission to discuss my account, billing information, appointment dates, medical conditions, symptoms, treatment, test results, medications and any other type of protected health information with the following person(s):

1 _____
Name Relationship

2 _____
Name Relationship

□ I DO NOT give permission for my information to be discussed with anyone other than myself without my written consent.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it at any time by writing to Anniston Orthopaedic Associates, P.A or by completing a new form. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above listed individual(s) it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____