SOUTHSIDE
ORTHOPAEDICS P.C.

**PATIENT INFORMATION**

**My appointment today is with:** ☐ **Dr. Regan** ☐ **Dr. Liston** ☐ **Dr. Cotton**

**Name:**_____**S.S.#**_____/_____/_____

**Birth Date:**_____/_____/_____ **Sex: Male / Female** **Marital Status: S___W___D___M___**

**Street Address:**_____**City:**_____**State:**_____**Zip:**_____

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

**E Mail:**_____**Decline email:** ☐ **Preferred form of communication:**_____

**Local Pharmacy Name:**_____**Location:**_____**(town,cross street or zip)**

**Employer Name:**_____**Location:**_____

**Emergency Contact Person:**_____**Phone:**_____**Relationship:**_____

**IF PATIENT IS A MINOR(UNDER 18 YEARS OLD). COMPLETE THE NEXT 3 LINES**

**Person responsible for payment:**_____**Phone#:**_____

**Birth date:**_____/_____/_____**S.S#**_____/_____/_____**Relationship to patient:**_____

**Street Address:**_____**City, State, Zip:**_____

**Primary Insurance** **Secondary Insurance**

**Ins. Co. Name:**_____**Ins. Co. Name:**_____

**Policy Owner Name:**_____**Policy Owner Name:**_____

**Birthdate of Policy Owner:**_____**Birthdate of Policy Owner:**_____

**Relationship to Policy Owner:**_____**Relationship to Policy Owner:**_____

**By my signature below, I hereby request and consent to medical treatment and I authorize the release of medical information as outlined in the Practice Privacy of Information Policy I have been given. I authorize payment directly to the physician or supplier for services rendered and I recognize that I am ultimately responsible for payment for services regardless of insurance coverage or non-coverage.**

**Authorized Signature:**_____**Date:**_____

*Please do not fill out below this line unless instructed by staff to do so*

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***********In reviewing the above information I find it to be current and accurate and I renew my above authorization: (Please initial and date below.)**