VALLEY Sports & Spine CLINIC

Patient Demographics

Ethan B. Colliver, DO
Thomas E. DiCarlo, MD

Today's Date _____/_____/_____ **Date of Appointment** _____/_____/_____

Patent's Referring Physician_____

Patient's Primary Care Physician_____

Patients First Name _____**MI**_____ **Last Name**_____

Social Security Number_____ **Date of Birth (MM/DD/YYYY)** _____/_____/_____

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____ **Work Phone** (_____) _____-_____

Patient's Address: _____

APT #_____**Zip Code** _____**City**_____ **State**_____

Patient Employer: _____ **Patient Email:** _____

(Please Circle One)

Sex: Male / Female **Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Unknown

Race: American Indian / Asian / African American / White / Other_____

Marital Status: Single / Married / Divorced / Widowed

If Married: Spouses First Name _____**Last Name** _____

Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____ **Work Phone** (_____) _____-_____

Social Security Number_____ **Date of Birth (MM/DD/YYYY)** _____/_____/_____

- ***If you are providing the information above for a patient under the age of 18 years old, please complete the following.***

Parent/Guardian's Name _____

SSN _____ **Date of Birth**_____/_____/_____ **Relationship to Patient**_____

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____ **Work Phone** (_____) _____-_____

Address (if different from above):

How did you hear about us?

- ☐ **Doctor Referral**
- ☐ **Family / Friend**
- ☐ **Google Ad**
- ☐ **Facebook**
- ☐ **Other**_____

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I hereby authorize Valley Sports & Spine Clinic to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Valley Sports & spine Clinic of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original. I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

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I request and authorize Valley Sports & Spine Clinic to disclose protected health care information to the individuals listed below.

Name _____ Contact # _____

Name _____ Contact # _____

Name _____ Contact # _____

I acknowledge that Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

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I hereby consent to Valley Sports & Spine Clinic using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendering to me or to carry out the Practice's health care operations. I also consent to Valley Sports & Spine Clinic using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider, or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

_____ _____

Patient's Signature (or responsible party) Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient