CATALYST Medical Group | Lewiston Orthopaedics

320 Warner Drive | Lewiston, ID 83501
(208) 743-3523 | (800) 841-3523 | Fax (208) 746-8741
www.lewistonortho.com
www.catalystmedicalgroup.com

Patient Information Form

Patient _____ DOB _____ Age _____
Last Name First Name Middle

SS#_____ Sex: ☐ M ☐ F Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Race: ☐ White ☐ American Indian ☐ Hispanic/Latino ☐ African American ☐ Other Ethnicity

Mailing Address_____City/State/Zip_____

Physical Address _____ City/State/Zip _____ Home # _____

Cell # _____ Work # _____ Email Address _____

Employer _____ Spouse's Name _____ SS# _____

DOB _____ Spouse's Employer _____

Responsible Person if Other Than Patient or if Patient is a Minor

Name_____Relationship_____

Address_____City/State/Zip_____

Home#_____Cell#_____Work#_____

Employer _____

Emergency Contact Information

Name _____ Relationship _____ Phone # _____

Primary Insurance Information

Insurance Co. Name _____Policy Holder _____

Group # _____ ID/Policy #_____

Policy Holder DOB _____ Relationship to Patient _____

Secondary Insurance Information

Insurance Co. Name _____Policy Holder _____

Group # _____ ID/Policy # _____

Policy Holder DOB _____ Relationship to Patient _____

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Consent for Treatment

Date of Injury _____ □ Right □ Left Body Part _____

Brief Description of How and Where Injury Occurred _____

_____

Is Injury Work Related? □ Yes □ No

Workers' Compensation Insurance (If Applicable)

Employer _____ Claim # _____Adjuster _____

PH _____

Auto Accident? □ Yes □ No

Carrier _____ Address _____

Claim #_____Adjuster _____

Primary Care Physician _____

Who Referred You to Our Office? _____

Consent for Treatment

I hereby authorize necessary medical care to be rendered to the patient registers hereon.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT/FINANCIAL RESPONSIBILITY:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I hereby assign any insurance benefits and authorize the release of medical information for the purpose of treatment, payment, and healthcare operations to Lewiston Orthopaedics for services rendered for which I acknowledge responsibility, whether or not they are covered by insurance.

Signature _____Date _____