

Patient Information Form

Welcome to *Orthopaedic Associates of Northern New Mexico, P.C. (OANNM)* and *St. Vincent Hospital Orthopaedic Group (SVHOG)*. We are happy you have chosen us as your health partner.

In order to better serve you, we require the following information to be completed in full or 'N/A' if not applicable.

Patient Information			Responsible Party, Spouse or Parent Information		
Last Name	First Name		Last Name	First Name	
Mailing Address			Mailing Address (if different than Patient's)		
Address, cont.			Address, cont.		
City	State	Zip Code	City	State	Zip Code
Home Telephone Number	Alternative / Work Telephone		Home Telephone Number	Alternative / Work Telephone	
Date of Birth	Social Security Number		Social Security Number	Relationship to Patient	Date of Birth
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Employer	Referring Doctor	
Emergency Contact Information					
Name		Relationship	Telephone Number	Alternative / Work Telephone	
Review of Patient Rights and Responsibilities					
By signing below, I (Patient or Responsible Party) have read and understand the Patient Rights and Responsibilities of either Orthopaedic Associates of Northern New Mexico (OANNM) or St. Vincent Hospital Orthopaedic Group (SVHOG), dependent upon which entity is providing services, and agree to abide by these policies while I (Patient or Responsible Party) am under their care. I understand I can request a copy of these rights and responsibilities to refer to as necessary.					
Signature		Print Name		Date	
Payment Policy					
Statements are mailed out once a month on unpaid balances. If payment is not received within 90 days on your account, your account will be handed over to an outside collection agency. This could affect your ability to obtain credit in the future.					
I authorize OANNM, P.C. or SVHOG to release any protected medical information necessary in order to process my insurance claim. I authorize payment of the surgical and/or medical benefits due me directly to ORTHOPAEDIC ASSOCIATES OF NORTHERN NEW MEXICO, P.C. or ST. VINCENT HOSPITAL ORTHOPAEDIC GROUP , dependent upon which entity provided services. I understand that my signature below indicates that I am responsible for payment of this account within the limits of the office's credit policies unless other financial arrangements are made in advance.					
Signature		Print Name		Date	