REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's Last name: First: MI:	Date of Birth:	Sex:
Address:	Cell Phone: Home Phone:	Allow text: □ Yes □ No
Email:	**May we leave a detailed message including medical information on your voicemail? Yes___ No___**	

Ethnicity:	Race:	Preferred Language:
Referring Physician		Primary Care Physician:

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Parent/ Guardian's Last Name: First: MI:	Date of Birth:	Primary Phone:
Address (if different than above):		Secondary Phone:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered a copy of this Thornapple River Orthopedics Notice of Privacy Practices.

Signature: Date:

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

Authorized Contacts:

I authorize my physician and/ or administrative and clinical staff to disclose protected health information to:

Name:	Relationship to Patient:	Contact Number:

This authorization shall be in force and effective until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at Thornapple River Orthopedics at 7169 Kalamazoo Ave SE Suite 100 Caledonia, MI 49316. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian signature:

Date: