CLEVELAND ORTHOPEDIC & SPINE INSTITUTE

Patient: _____

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____ SSN#: _____

City: _____ State: _____ ZIP: _____

Email: _____ Primary Phone: _____

Home Phone: _____ Leave Message: ◯ Yes ◯ No

Race: _____ Language:: _____ Ethnicity: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Primary Care Physician: _____ Referring Doctor: _____

Pharmacy: _____ City, State: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ ZIP: _____

Occupation: _____ Status: ◯ Full Time ◯ Part Time ◯ Retired

Are you unhoused? ◯ Yes ◯ No If yes, would you like a member of our Care Team to contact you regarding available resources? ◯ Yes ◯ No

If your food runs out for the month, do you have money to buy more? ◯ Yes ◯ No

If you answered no, would you like someone from the Care Team to contact you regarding resources for food assistance? ◯ Yes ◯ No

Do you have any special communication needs? ◯ Yes ◯ No

INSURANCE INFORMATION

◯ No Medical Insurance

◯ Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

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Patient: _____

Date : _____

Person Responsible for Any Patient Balance: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone: _____ Employer: _____

Emergency Contact Name: _____ Primary Phone: _____

Relationship: _____

Height: _____ Weight: _____

Have you had your flu shot this year? ◯ Yes ◯ No Smoking Status: ◯ Never ◯ Former ◯ Current

List of Medications and dosage: _____

_____

Medication Allergies and Reactions: _____

_____

Medical and Surgical History (Diabetes, Shoulder Replacement, etc.)

_____

Recent Hospitalizations: _____

How Did You Hear about us? Social Media: ◯ Referral from Friend: ◯ Google Search: ◯

Other: _____

In the event that I (or in the case of a minor, the personal representative of said minor) cannot be reached directly to discuss Patient Health Information, COSI is authorized to leave a message by voice mail, with any individual listed above (emergency contact) or with any individual that answer the phone using the numbers provided.

Parent or Guardian Signature: _____ Date: _____

Patient Signature: _____ Date: _____