Voytik Center *for* Orthopedic Care

PATIENT INFORMATION FORM

Gary J. Voytik, D.O.
Osteopathic Physician and Board Certified Orthopedic Surgeon

Brandon West PA-C
Certified Physician Assistant

Kerri Hopkins FNP-C
Certified Nurse Practitioner

Date:_____ ___ Male ___ Female / Preferred Language _____

Patient's Full Name:_____ DOB _____ Age: _____SS#: _____

Address:_____ City:_____ State:_____ Zip_____

Phone Numbers: (Home)_____ (Cell)_____ (Alternate)_____

_____Please Initial: By providing any phone number, including cell phone numbers, I consent to receive calls for appointment reminders, test results, continuation of care, balance reminders and collection calls that could be prerecorded.

Email Address:_____ (**Please Print Clear**)
_____ Please Initial: By providing an email address, I consent to receive E-statements. If I choose not to provide an email, I am subject to a paper statement fee of $2.50.

Race: (circle one) Black / White / Asian / Native American / Native Hawaiian / Other **Ethnicity:** (circle one) Hispanic / Non-Hispanic / Other

Employer:_____ Occupation:_____
__Single __ Widowed __Divorced __Married/Spouse's Name:_____

Responsible Party If Patient Is a Minor

Name:_____ Relationship: _____ SS#: _____ D.O.B_____
Address:_____ City:_____ State: _____ Zip_____
Best Contact Phone# (s):_____ Employer: _____

Emergency Contact Residing At a Different Address

First
Contact Name:_____ Relationship:_____ Phone:_____
Second
Contact Name:_____ Relationship:_____ Phone:_____

Family Physician:_____ Referring Physician:_____
******HOW DID YOU HEAR ABOUT OUR OFFICE?**_____

Insurance Information

Primary Insurance:_____ ID#_____ Group#_____
Insured Name: _____Relationship: _____ DOB: _____ SS#: _____

Secondary Insurance: _____ ID#: _____ Group# _____
Insured Name: _____Relationship: _____ DOB: _____ SS#: _____

Patient Portal

Our office now has a patient portal, as part of a healthcare regulation that requires practices to deliver health information to patients via secure portal. If you would like to have access to our patient portal please let our front office know and we will send you an invite to the email you have provided.

Medication Policy

Prescriptions will be called into your pharmacy ONLY in an emergency situation.

*It is our office policy to list a primary pharmacy for your prescriptions to be called in to.
*__PAIN MEDICATION__ will not be called in after hours or on weekends. **NO EXCEPTIONS!**
*In addition, we will **NOT** call in early **prescription refills. NO EXCEPTIONS!**
*If our office is notified that you are receiving pain medication from another physician, while under our care, we will **no longer** provide pain medication for you at any time.
*Please address your need for prescription refills at the time of your appointment.
*Our office no longer accepts prescription request by phone.

_____ _____ _____
PRIMARY PHARMACY **STREET NAME** **PHONE NUMBER**

Pain Management

*Are you currently under contract with a pain management physician? ____Yes ____No
If Yes, Physician's Name_____ Office Number_____

*Are you currently receiving monthly prescriptions of pain medication from your Primary Care Physician? ____Yes ____No

**As a service to our clients, we provide courtesy appointment reminder communication and possibly other important communication that may be placed using a prerecorded message or email content. By providing the above numbers and email address, you consent to receiving such communication from your healthcare provider.*

CONSENT TO TREAT The undersigned voluntarily consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, as well as by authorized members of Voytik Center for Orthopedic Care or their designees. This may include, but are not limited to, the rendering of such care, including diagnostic procedures, laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician, as may in their professional judgement be necessary.

Patient/Guardian Signature_____ Date _____ Revised 3.23.17