PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Registration Form

Patient's Information

Last Name: Anderson First Name: Sarah Middle Initial: M

Date of Birth: 03/15/1985 Primary Contact Number: Cell Home Work

Cell Phone: (555) 123-4567 Home Phone: (555) 234-5678 Work Phone: (555) 345-6789

Email address: sarah.anderson@example.com

Emergency Contact

Full Name: Michael Anderson Relationship: Spouse

Primary Contact Number: (555) 123-4567 Cell Home Work

Alternate Contact Number: (555) 234-5678 Cell Home Work

Contact Preferences

I wish to be contacted in the following manner: (check all that apply)	OK To leave a message with Detailed information?	Leave message with call back number only
Cell	Cell	Cell
Home	Home	Home
Work	Work	Work
Email	Email (see email request form)	Email

Automated Appointment Reminders

Precision Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

Disclosure of Medical Information

I hereby give permission to Precision Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name: Emily Rodriguez Relationship: Sister

Full Name: Robert Thompson Relationship: Father

Full Name: Jennifer Chen Relationship: Friend

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

Notice of Privacy Practices

SA I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
(Initials)

Facsimile Authorization for Coordination of Care

I, the undersigned, authorize POSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary **coordination of care** for the patient listed below. **Medical records requests require separate form and authorization from this Facsimile Authorization**. I may revoke this authorization by giving POSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to POSM as well.**

Signature: Date: 10/15/2025