The Ryu Hurvitz Orthopedic Clinic

2936 De La Vina Street First Floor
Santa Barbara CA 93105
Telephone (805) 963-2729
Fax (805) 963-3818

Patient Information

Last Name: _____ First: _____ Middle: _____

Nickname/Preferred Name: _____ Pronouns: _____ Sex: M / F

Date of Birth: _____ Age: _____ SS#: _____ Marital Status: _____

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Preferred: H / C

Email Address: _____

Emergency Contact: _____ Phone Number: _____

Primary Care Practitioner: _____

Referring Practitioner (if applicable): _____

For Appointment Reminders: email / text

Please note that our physicians use different systems. Reminders are not sent for Dr. Richard Ryu.

Insurance Information

The Primary Subscriber is the individual who is the primary account holder for your insurance policy. This may be you (the patient), your spouse, your parent, or someone else.

Name of Primary Subscriber: _____ Primary Subscriber DOB: _____

Patient's Relationship to Primary Subscriber: _____

Privacy Notice Acknowledgement

The Ryu Hurvitz Orthopedic Clinic is in strict adherence with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will not disclose your health information to any unauthorized sources.

I acknowledge the Notice of Privacy Practices from the Ryu Hurvitz Orthopedic Clinic. I am aware that a paper copy of this Notice will be provided at my request.

Initials: _____

Authorization of Disclosure

I hereby authorize discussion of my general medical condition, diagnosis, treatment, appointments, payment, and healthcare options with (check all that apply)**:**

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☐ Spouse (name and phone number): _____

☐ Parent (name and phone number): _____

☐ Children (name and phone number): _____

☐ Other (relationship, name, and phone number): _____

Initials: _____

Surrogate Decision Maker

You have the choice of naming a surrogate decision maker in case you are not able to make decisions.

☐ My surrogate decision maker will be (name): _____

Relationship: _____ Phone Number: _____

☐ I decline to name a surrogate decision maker at this time.

Initials: _____

Injury

Body Part Injured: _____ ☐ Right ☐ Left Date of Injury: _____

Brief description of the injury: _____

_____

Was the injury work-related? ☐ Yes ☐ No

Will you be filing a worker's compensation claim? ☐ Yes ☐ No

Please note that worker's compensation claims require separate authorization. If you are considering filing a worker's compensation claim for your injury, please let our office know immediately.

_____ _____ _____

Patient Name Patient Signature Date

If this form has been filled out on behalf of the patient:

_____ _____ _____

Name of Person Completing Form Relationship to Patient Date