**Dirk R. Diefendorf, M.D.**
ORTHOPEDIC SURGERY - SPORTS MEDICINE


Date:___________

Name ___________________________________________ Date of Birth ___________ Age ______ Sex: M F

Address ______________________________________________________________________________________

City ___________________________________________________ State ______ Zip code ___________

Lives with (check one) Alone/Self Spouse/Partner Both Parents Mom Dad Other ______________

PHONE Home # ______________________ Work # ________________________ Cell# _______________________

Email: _______________________________________________________________________________________

SS# ____-___-_______ Marital Status: S M W D Spouse/Partner __________________________________

Employer/Name of School _____________________________________ Occupation _____________________________

Is your condition a result of a WORK related injury? YES or NO Auto Accident? YES or NO

Area(s) of complaint ____________________________________________ Date of injury _________________________

Have you had X-RAYS or an MRI taken? YES NO If so Where/When? _____________________________________

Please explain how injury occurred _______________________________________________________________________

RESPONSIBLE PARTY? _______________________________ DATE OF BIRTH ___________ SS#____ -___ -_______

RELATION TO PATIENT? _____________________________ DAYTIME PHONE # ________________________

EMERGENCY CONTACT ____________________________________________ RELATIONSHIP _____________________

ADDRESS ______________________________________ CITY _____________________ STATE ______ ZIP ___________

CELL PHONE _________________________ HOME PHONE ____________________ OTHER ______________________

REFERRED BY _________________________________________________________

PRIMARY CARE PHYSICIAN ______________________________________________

***In 1996 Congress passed a law called the Health Insurance Portability Accountability Act (HIPAA). This law became effective April 15th 2003. The law requires that we inform you of any use we make of our protected health information (PHI). Briefly, our office will use your PHI for continuing treatment and for billing purposes. This means that we may send your records to another treating Physician or Diagnostic Clinic or to your Insurance Company. Our complete privacy policy is on display in our reception area for your review.***
***I hereby acknowledge that I reviewed a copy of Dr. Diefendorf's Notice of Privacy Practice. I further acknowledge that a copy of the current notice is posted in the reception area.***

***Signed:_______________________________ Name of Patient/Relationship_________________________________________***