

Texas Orthopaedic Associates

RRS JAR MJC TGS RHB WRV JCW

Patient Legal Name: _____
Last First Middle Preferred Name

Address: _____ Home #: (____) _____
Street Apartment #

_____ Date of Birth: _____ Age: _____
City State Zip Code

Social Security #: _____ Driver's Lic. #: _____ Marital Status: S M D W Sex: F / M
State

Employer: _____ Work #: (____) _____
Company Name

Address: _____
Street Suite # City State Zip Code

Guarantor (if patient is a minor) or Spouse Information or Emergency Contact

Name: _____ Relationship: _____
Last First Middle

DOB: _____ SSN: _____ Home #: (____) _____ Marital Status: S M D W

Address: _____
Street Apartment # City State Zip Code

Employer: _____ Work #: (____) _____

Address: _____
Street Suite # City State Zip Code

Other Parent Information:

Name: _____ Relationship: _____ DOB: _____
Last First Middle

Address: _____
Street Apartment # City State Zip Code

Social Security #: _____ Home #: (____) _____ Work #: (____) _____

Family Doctor/PCP: _____ Phone #: (____) _____ Referred By: _____

Insurance Primary: _____ Phone #: (____) _____
Insurance Name

_____ ID #: _____ Group #: _____
Policy Holder's Name

Secondary: _____ Phone #: (____) _____
Insurance Name

_____ ID #: _____ Group #: _____
Policy Holder's Name

HMO
PPO
IN

Information Regarding Medical Problem

Date of Injury/ Onset: _____

Result of Accident? Y N Injured on the Job? Y* N In Automobile Accident? Y N

***If YES, Tell Receptionist**

Please Circle: Right / Left Finger Hand Wrist Arm Shoulder Elbow Back/Neck Hip Leg Knee Foot Ankle Toe
How did injury occur? Include location where it happened. _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Texas Orthopaedic Associates L.L.P. to release to my insurance company any information acquired in the course of my care and permit payment directly to Texas Orthopaedic Associates L.L.P. any benefits due for services rendered. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits.

Patient/Guardian Signature

Date