

# PATIENT INFORMATION



## PATIENT INFO

FIRST NAME:  MIDDLE NAME:  LAST NAME:  PREFERRED NAME:  SOCIAL SECURITY #:

AGE:  DATE OF BIRTH:    SEX:  Female  Male

ADDRESS:  APARTMENT #:  CITY:  STATE:  ZIP CODE:

MOBILE PHONE:    WORK PHONE:    HOME PHONE:    EMAIL ADDRESS:

EMPLOYER/COMPANY NAME:  ADDRESS:  SUITE #:

CITY:  STATE:  ZIP CODE:

## POLICY HOLDER (IF NOT PATIENT)

FIRST NAME:  LAST NAME:  RELATIONSHIP:  DATE OF BIRTH:    SOCIAL SECURITY #:

ADDRESS:  APARTMENT #:  CITY:  STATE:  ZIP CODE:

MOBILE PHONE:    WORK PHONE:    HOME PHONE:    EMAIL ADDRESS:

EMPLOYER/COMPANY NAME:  ADDRESS:  SUITE #:

CITY:  STATE:  ZIP CODE:

## EMERGENCY CONTACT / OTHER PARENT INFO (IF PATIENT IS A MINOR)

FIRST NAME:  LAST NAME:  RELATIONSHIP:

MOBILE PHONE:    WORK PHONE:    HOME PHONE:    EMAIL ADDRESS:

## INSURANCE INFO

PRIMARY INSURANCE COMPANY NAME:  SECONDARY INSURANCE COMPANY NAME:

POLICY HOLDER'S LEGAL NAME:  PHONE #:    POLICY HOLDER'S LEGAL NAME:  PHONE #:

ID#:  GROUP #:  ID#:  GROUP #:

## RELEASE OF INFO AND ASSIGNMENT OF BENEFITS

I authorize Texas Orthopaedic Associates L.L.P. to release my insurance company and 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.

\_\_\_\_\_ DATE: \_\_\_\_\_