# Patient Profile Sheet

TEXAS ORTHOPAEDIC ASSOCIATES

Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Number: _____ Work Number: _____ Cell Number: _____

Email Address: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Social Security Number: _____ Sex: Female or Male

Employer's Name: _____

Address: _____
Street City State Zip

Patient Occupation: _____ (If retired, please state so)

**INSURANCE INFORMATION:** *(If you have secondary insurance information, please advise receptionist)*

Name of Insurance Carrier: _____

Insured's Date of Birth: _____ Soc. Sec. No. of Insured: _____

Name of Insured: _____ Relationship to the Insured: Self Spouse Child Other

Name of Insured's Employer: _____

Address: _____
Street City State Zip

City, State, Zip Code: _____

Telephone Number: _____ Policy Number: _____ Group Number: _____

**Referring or Primary Care Doctor:** _____ Telephone Number: _____

Address: _____
Street City State Zip

How were you referred? _____

**Next of Kin/Emergency Contact:**

Name and Address: _____

Telephone Number: _____ Relationship to patient: _____

**Date of Injury:** _____

I authorize Texas Orthopaedic Associates to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with Texas Orthopaedic Associates. If surgery is required I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to Texas Orthopaedic Associates. This assignment will remain in effect until revoked by me in writing. A photocopy or assignment is to be considered as valid as an original. I understand any overpayment on my account will be promptly refunded.

Disclosure of Interest: Drs Paschal, Montgomery, Thornton and Payne have an ownership interest in Texas Institute for Surgery at Presbyterian Hospital of Dallas and as a result may financially benefit from the referral of services to the hospital in the form of increased dividends or distributions. You have the option of using an alternative health care facility. Please let us know if you have any concerns regarding the financial relationship between Dr's Paschal, Montgomery, Thornton and Payne and Texas Institute for Surgery at Presbyterian Hospital of Dallas.

**Signature:** _____ **Date:** _____