

ORTHOPAEDIC ASSOCIATES OF CORPUS CHRISTI

NEW PATIENT INFORMATION (PLEASE PRINT)

DATE:

PATIENT'S NAME		TDL #	DATE OF BIRTH	AGE	M OR F	SOCIAL SECURITY NO.
MAILING ADDRESS		PERMANENT	TEMPORARY	CITY, STATE AND ZIP CODE		(Area Code) CELL PHONE NO. (Area Code) HOME PHONE NO.
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF A STUDENT)		HOW LONG EMPLOYED	(Area Code) BUSINESS PHONE	
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE	NO. OF CHILDREN AND AGES	
SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY NO.			SPOUSE'S DATE OF BIRTH	
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF A STUDENT)		HOW LONG EMPLOYED	(Area Code) BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE	
RELATIVE OR FRIEND (CIRCLE)		CITY AND STATE		ZIP CODE	(Area Code) HOME PHONE NO.	
RELATIVE OR FRIEND (CIRCLE)		CITY AND STATE		ZIP CODE	(Area Code) HOME PHONE NO.	

PLEASE READ: --

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. THE PATIENT IS RESPONSIBLE FOR ALL FEES. REGARDLESS OF INSURANCE COVERAGE. COPIES OF YOUR FEE SLIP WILL BE PROVIDED TO YOU. THIS, WITH YOUR MONTHLY STATEMENT, MAY BE SUBMITTED TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

PRIMARY INSURANCE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY			NAME OF INSURANCE COMPANY		
ADDRESS TO MAIL CLAIMS			ADDRESS TO MAIL CLAIMS		
CITY AND STATE	ZIP CODE	(Area Code) BUSINESS PHONE	CITY AND STATE	ZIP CODE	(Area Code) BUSINESS PHONE
NAME OF INSURED		SOCIAL SECURITY NO.	NAME OF INSURED		SOCIAL SECURITY NO.
GROUP NO.			GROUP NO.		
POLICY NO.			POLICY NO.		
MEDICARE (PLEASE GIVE NUMBER) <input type="checkbox"/>			RAILROAD RETIREMENT (PLEASE GIVE NUMBER) <input type="checkbox"/>		
MEDICAID <input type="checkbox"/>	CASE NO.	EFFECTIVE DATE			
INDUSTRIAL <input type="checkbox"/>	WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF INJURY	INDUSTRIAL CLAIM NUMBER	
ACCIDENT <input type="checkbox"/>	WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENT	ATTORNEY CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF ATTORNEY	
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)			DATE X-RAYS TAKEN
HAVE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE?					WHEN
REFERRED BY		STREET ADDRESS, CITY, STATE AND ZIP CODE			(Area Code) PHONE NO.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE _____ M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE _____