

TEXAS SPORTS MEDICINE AND ORTHOPAEDIC GROUP

Patient Demographic & Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

TODAY'S DATE: _____

Name: _____ Nickname: _____

(FULL LEGAL NAME: FIRST, THEN LAST NAME)

(IF ANY)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell phone: (____) _____ Gender: Male / Female

SS#: _____ Birthdate: _____ Height: _____ Weight: _____

Marital Status: Single Married Divorced Widowed E-mail address: _____

Employer: _____ Occupation: _____

Work Phone: (____) _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Address: _____ Phone: (____) _____

EMERGENCY CONTACT PERSON: (MUST ALSO BE LISTED ON YOUR HIPAA FORM) _____

RELATIONSHIP TO YOU: _____ PHONE # WHERE THEY CAN BE REACHED: _____

What are we seeing you for today? Left / Right (body part) _____ Cervical / Thoracic / Lumbar Spine

Is this injury sports related? YES NO **Date of Injury:** _____

Please give the details of how injury occurred: _____

Where did injury occur? (Geographical location, not body part) _____

PRIMARY INSURANCE COMPANY: _____ Phone: (____) _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policyholder's Name: _____ Policyholder's DOB: _____

Policyholder's SS#: _____ ID# on Card: _____

Grp/Policy # _____ Relationship of the patient to the policyholder: SELF SPOUSE DEPENDANT

SECONDARY INSURANCE COMPANY: _____ Phone: (____) _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policyholder's Name: _____ Policyholder's DOB: _____

Policyholder's SS#: _____ ID# on Card: _____

Grp/Policy # _____ Relationship of the patient to the policyholder: SELF SPOUSE DEPENDANT

RESPONSIBLE PARTY FOR THIS ACCOUNT? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

MEDICAL INFORMATION:

PLEASE LIST ALL KNOWN DRUG ALLERGIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

TOBACCO USE: _____ packs per day _____ years ALCOHOL USE: _____ drinks per day

PRIMARY CARE PHYSICIAN'S NAME: _____ Phone: (_____) _____

RECENT ILLNESSES OR SYMPTOMS: _____

PREVIOUS SURGERY (Please list and give dates): _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS OR ILLNESSES? (Please answer yes or no to each or circle NONE)

Abnormal Blood Pressure _____	Heart Disease _____	Infectious Disease _____
Hepatitis _____	Anemia _____	Stomach Ulcers _____
Blood Disorders _____	Stroke _____	Cancer _____
Diabetes _____	Blood Transfusions _____	High Cholesterol: _____
Asthma _____	Reflux _____	NONE

Other Medical Conditions/Illnesses not listed above: _____

Please give details if you answered "yes" to any of the above: _____

I hereby give permission to **TEXAS SPORTS MEDICINE & ORTHOPAEDIC GROUP** and its staff to provide my daughter/son with evaluation (including X-rays) and treatment for his/her injuries.

****DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE INSURANCE OR FINANCIAL RESPONSIBILITY. TEXAS SPORTS MEDICINE & ORTHOPAEDIC GROUP WILL NOT BILL OR DISCUSS TREATMENT WITH THE OTHER PARENT.**

I hereby authorize Texas Sports Medicine & Orthopaedic Group to furnish information to insurance carrier concerning me and/or my dependants illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and / or my dependants for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information on this form is true and correct to the best of my knowledge and I will notify TEXAS SPORTS MEDICINE & ORTHOPAEDIC GROUP of any changes. (A copy of this authorization shall be as valid as the original.)

Your receipt will provide all the necessary information for you to file with your insurance company if our office is not contracted with or filing to your insurance carrier.

I WILL BE PAYING TODAY BY: CASH _____ CHECK _____ DL# _____

 CREDIT CARD: MASTERCARD _____ VISA _____ ATM/DEBIT _____

SIGNATURE of PATIENT: _____ DATE: _____

If patient is a minor (under the age of 18), parent or legal guardian must sign.