# 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)** ❑ | | | RAILROAD RETIREMENT (PLEASE GIVE NUMBER) ❑ | | |

| **MEDICAID** ❑ | CASE NO. | EFFECTIVE DATE |
|---|---|---|
| | | |

| INDUSTRIAL ❑ | WERE YOU INJURED ON THE JOB? ❑ YES ❑ NO | DATE OF INJURY | INDUSTRIAL CLAIM NUMBER |
|---|---|---|---|
| | | | |

| ACCIDENT ❑ | WAS AN AUTOMOBILE INVOLVED? ❑ YES ❑ NO | DATE OF ACCIDENT | ATTORNEY CASE? ❑ YES ❑ NO | NAME OF ATTORNEY |
|---|---|---|---|---|
| | | | | |

| WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ❑ YES ❑ 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 _____