

**THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI**

OFFICE USE ONLY: DOCTOR# \_\_\_\_\_ NEW PT \_\_\_\_\_ EST.PT \_\_\_\_\_ UPDATE \_\_\_\_\_

**PATIENT INFORMATION**  
(PLEASE PRINT)

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MARITAL STATUS S M D W

PATIENT'S LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#/LOT#: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME#: \_\_\_\_\_ WK#: \_\_\_\_\_ CELL#: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ E-MAIL ADD: \_\_\_\_\_

MAILING ADDRESS IF DIFFERENT FROM ABOVE: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_ WK#: \_\_\_\_\_ CELL#: \_\_\_\_\_

FAMILY PHYSICIAN'S NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

IF REFERRED BY A PHYSICIAN, HAS HE OR SHE EVALUATED OR TREATED YOU FOR THIS INJURY AND/OR SYMPTOM? \_\_\_\_\_ IF YES, PHYSICIAN'S NAME: \_\_\_\_\_

\*\*\*\*\*REQUIRED IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)\*\*\*\*\*

MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME# \_\_\_\_\_ WORK# \_\_\_\_\_ HOME# \_\_\_\_\_ WORK# \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ INSURED'S NAME: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_ INSURED'S EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ INSURED'S EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

I HEREBY AUTHORIZE PAYMENTS BY MY MEDICAL INSURANCE PLAN, BE MADE PAYABLE TO THE PHYSICIAN(S) AT THE ORTHOPAEDIC CENTER OF CORPUS CHRISTI. THIS AUTHORIZATION IS INDEFINITE FOR ANY AND ALL TREATMENT I RECEIVE. I UNDERSTAND THIS AUTHORIZATION DOES NOT RELEASE ME FROM THE RESPONSIBILITY OF PAYMENT FOR ALL CHARGES NOT COVERED BY MY INSURANCE. IT IS MY RESPONSIBILITY TO KNOW WHAT MY MEDICAL BENEFITS ARE IN REGARDS TO MY DEDUCTIBLE, CO-PAY AND OUT OF POCKET EXPENSES. CO-PAYS AND DEDUCTIBLES WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED. **PAYMENT OF SELF PAY PATIENTS IS EXPECTED AT THE TIME SERVICES ARE RENDERED.**

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_