



Southwest Sports Medicine and Orthopaedics

Patient Demographic and Insurance Information

Please Print

Patient:

Patient's Name: _____

Sex: Male Female

Mailing Address: _____

Marital Status: Married Single Divorced Widowed

City: _____

Employment Status: Employed Unemployed Retired Student

State: _____ Zip: _____

IF EMPLOYED: Patient's Employer: _____

Home phone: (____) _____

IF STUDENT: School: _____

Cell phone: (____) _____

IF MARRIED: Spouse's Name: _____

Work phone: (____) _____

Phone: (____) _____

Date of Birth: _____ Age: _____

Preferred Pharmacy : _____

Social Security No.: _____

Emergency Contacts:

Who referred you to this practice? _____

Name: _____ Ph: _____

Regular Medical Doctor: _____

Name: _____ Ph: _____

In order to provide you with the best medical care we routinely send clinic notes to your regular medical doctor

Guarantor (where the bills will be sent):

Name: _____

Sex: Male Female

Address: _____

Date of Birth: _____

City: _____

Relationship to Patient: _____

State: _____ Zip: _____

Phone No.: _____

In order for us to file your insurance, the following MUST be complete.

Primary Insurance Information:

Insurance Company: _____ Id No.: _____ Group No. : _____

Cardholder Name: _____

Sex: Male Female

Address: _____

Date of Birth: _____

City: _____

Social Security No.: _____

State: _____ Zip: _____

Relationship to Patient: _____

Phone No.: _____

Employer: _____

Secondary Insurance Information:

Insurance Company: _____ Id No.: _____ Group No. : _____

Cardholder Name: _____

Sex: Male Female

Address: _____

Date of Birth: _____

City: _____

Social Security No.: _____

State: _____ Zip: _____

Relationship to Patient: _____

Phone No.: _____

Employer: _____



Southwest Sports Medicine and Orthopaedics

Patient Medical Information

Patient Name: _____

Orthopaedic History

Please tell us why you have come to the doctor today. Include whether it is the right or left side. Is this an injury? If so, please give the date and circumstance of the injury.

Have you received any treatment for this problem?

Do you have any previous history of problems involving this extremity?

Medical History

Present medications (Please list prescription, over-the-counter, vitamins and herbal supplements):

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to:

Penicillin?	YES	NO
Codeine?.....	YES	NO
Sulfa Drugs?.....	YES	NO

Please list other medications you are allergic to:

List hospitalizations or surgeries:

Do you have any of the following medical conditions?

Asthma	Yes	No	High blood pressure	Yes	No	A positive Aids test? Yes	No
Bleeding Tendency	Yes	No	HIV	Yes	No	At risk for Aids? Yes	No
Blood Disorder	Yes	No	Keloids(excessive scarring)	Yes	No		
Cancer	Yes	No	Kidney/Bladder problems	Yes	No		
Diabetes	Yes	No	Nose bleeds	Yes	No	When was your last tetanus	
Duodenal Ulcer	Yes	No	Rheumatoid arthritis	Yes	No	shot?_____	
Epilepsy	Yes	No	Tuberculosis	Yes	No		
Heart Problems	Yes	No	Psychiatric problems	Yes	No	List daily consumption of	
Hemophilia	Yes	No	If yes, have you seen a			Tobacco_____	
Hepatitis	Yes	No	psychiatrist?	Yes	No	Alcohol_____	

Signature: _____

Date: _____

Note: If the patient is a minor, parent or guardian must sign.



Southwest Sports Medicine and Orthopaedics

Fees for services are due and payable at the time service is rendered. Southwest Sports Medicine and Orthopaedics will file charges with your insurance company, however, patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance company.

I hereby authorize Southwest Sports Medicine and Orthopaedics and its doctors to furnish medical information to my insurance carrier concerning my and/or my dependents' illness and treatments. A photo copy of this assignment and release shall be effective and valid as an original for the duration of my treatment. I assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand and agree that, regardless of my insurance status, I am ultimately responsible for any fees for professional services rendered.

I hereby authorize Southwest Sports Medicine and Orthopaedics and its doctors to administer in this office such medications and treatments as are necessary on the basis of findings in my case. I also consent to the administrations of such anesthetics as are necessary.

I acknowledge that I have been made aware and offered a copy of Southwest Sports Medicine and Orthopaedics privacy policy relating to the handling of my private health information.

I certify that the information on this form is true and correct to the best of my knowledge and that I will notify Southwest Sports Medicine and Orthopaedics of any changes.

I acknowledge that the insurance information is correct. I acknowledge that my injury *is not related to work*. (If your injury is a work- related injury you must contact your employer and have them set up an appointment with a Texas Worker's Compensation doctor. You may *not* keep this appointment, give us your personal insurance and decide at a later date that what you are being seen for today is a work- related injury.)

X _____
Patient/Guarantor's Signature

Date: _____