# Texas Knee & Sports Medicine Center - Patient Registration

BILLING CLASS ______________________________

## INFORMATION ABOUT THE PATIENT:

| Name (last, first, middle initial) | Social Security Number: | Birthdate: |
|---|---|---|
| | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Age: | Sex: M F | Home Phone Number: | Cell: | Occupation: | Employer: |
|---|---|---|---|---|---|
| | | | | | |

| Employer Address: | City: | State: | Zip: | Business Phone: |
|---|---|---|---|---|
| | | | | |

| Relationship to Person Responsible for Payment: | Status: |
|---|---|
| Self (1) ________ Spouse (2) ________ Child (3) ________ Other (4) ________ | Married (M) ________ Single (S) ________ Divorced (D) ________ Widow/Widower (W) ________ |

| Spouse Name: | Spouse Social Security Number: | Spouse Employer: |
|---|---|---|
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| Spouse Employer Address: | City: | State: | Zip: |
|---|---|---|---|
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| Person to Contact in Case of Emergency: | Phone Number: | Business Phone Number: |
|---|---|---|
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| Address: | City: | State: | Zip: |
|---|---|---|---|
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| Referral Source: | E-mail Address: |
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## MEDICAL INFORMATION ABOUT THE PATIENT:

| IMPORTANT: Please list any allergies to medication of any kind: | Who is your personal doctor? |
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| | |

What is your current medical ailment?

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|---|---|---|---|---|---|---|
| Neck | Shoulder, L - R | Finger, L - R | Leg, L - R | Upper back | Arm, L - R | Wrist, L - R |
| Ankle, L - R | Lower back | Elbow, L - R | Foot, L - R | | Tailbone | Hand, L - R |
| Knee, L - R | Toe, L - R | | | | | |

| Date ailment first occurred: | Auto Accident? Yes ________ No ________ | Were X-rays taken? Yes / No | If yes, Where: | Date of Accident: |
|---|---|---|---|---|
| | | | | |

Did this injury happen on the job? ________ Yes ________ No Are you claiming Work Compensation? ________ Yes ________ No Have you notified your employer? ________ Yes ________ No

Describe how injury occurred:

## INFORMATION ABOUT THE INSURANCE POLICY HOLDER:

| Name (last, first, middle initial) | Home Phone: | Business Phone: | Drivers License Number: |
|---|---|---|---|
| | | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Employer: | Social Security Number: | Birthdate: |
|---|---|---|
| | | |

| Employer Address: | City: | State: | Zip: | Business Phone: |
|---|---|---|---|---|
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## INFORMATION ABOUT THE INSURANCE POLICY HOLDER:

Primary Insurance Carrier: (Insurance company name)

| Insurance Company Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Insurance Company Phone Number: | If Group Coverage Name of Employer: |
|---|---|
| | |

| I.D. Number: | Group Number: | Patient's Relationship to Person Covered by Insurance: Self (1) Spouse (2) Child (3) Other (4) |
|---|---|---|
| | | |

| Insured's Name: | Insured's Social Security Number: | Have you met your current year's deductible? Yes No |
|---|---|---|
| | | |

I Authorize the Texas Knee and Sports Medicine Center to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and surgical benefits to include Major Medical and Surgical Benefit to which I am entitled to the Texas Knee and Sports Medicine Center. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges.

PATIENT: ______________________________ SIGNED BY: ______________________________ DATE: ______________________________