MINOR PATIENTS UNDER AGE 18

SOUTH TEXAS BONE & JOINT

NEW PATIENT INFORMATION (PLEASE PRINT) DATE:

PATIENT'S NAME	EMAIL	DATE OF BIRTH	AGE	M/ F	SOCIAL SECURITY #

MAILING ADDRESS PERMANENT OR TEMPORARY	CITY, STATE, ZIP CODE	(AREA CODE) CELL PHONE#	(AREA CODE) HOME PHONE #

FATHER'S NAME	FATHER'S EMPLOYER		(AREA CODE) CELL PHONE#
EMPLOYER'S STREET ADDRESS	OCCUPATION	HOW LONG EMPLOYED	(AREA CODE) BUSINESS PH#
MOTHER'S NAME	MOTHER'S EMPLOYER		(AREA CODE) CELL PHONE#
EMPLOYER'S STREET ADDRESS	OCCUPATION	HOW LONG EMPLOYED	(AREA CODE) BUSINESS PH#
PARENT'S MAILING ADDRESS IF DIFFERENT	CITY, STATE, ZIP CODE		(AREA CODE) HOME PHONE #
RELATIVE OR FRIEND (CIRCLE)	CITY, STATE, ZIP CODE		(AREA CODE) HOME PHONE #
RELATIVE OR FRIEND (CIRCLE)	CITY, STATE, ZIP CODE		(AREA CODE) HOME PHONE #

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 PH#	CITY AND STATE	ZIP CODE	(AREA CODE) BUSINESS PH#
NAME OF INSURED	SOCIAL SECURITY #		NAME OF INSURED	SOCIAL SECURITY #	
GROUP #			GROUP #		
POLICY #			POLICY #		
MEDICARE (PLEASE GIVE NUMBER) ☐			RAILROAD RETIREMENT (PLEASE GIVE NUMBER) ☐		
MEDICAID ☐	CASE #		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 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? ☐ YES ☐ NO		WHEN?
REFERRED BY	STREET ADDRESS, CITY, STATE AND ZIP CODE	(AREA CODE) PHONE #

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 _____