SOUTH TEXAS ORTHOPAEDIC & SPINAL SURGERY ASSOCIATES
PATIENT INFORMATION RECORD

ACCOUNT#: ___________________________________ DRIVER'S LICENSE#: ____

NAME:____
FIRST MIDDLE LAST

ADDRESS: ____
STREET APT# CITY, STATE ZIP CODE

HOME PHONE: ___________________________ CELL PHONE: ____________________________ DOB: ________________________

WHO REFERRED YOU? ____SOCIAL SECURITY#: __________________________________

AGE: _______ CIRLCLE: MALE FEMALE SINGLE MARRIED DIVORCED SEPARATED WIDOWED

EMPLOYER: ____ PHONE# ____

ADDRESS: ____
STREET APT# CITY, STATE ZIP CODE

SPOUSE'S NAME: ____PHONE#: ____

TO BE COMPLETED BY WORKER'S COMPENSATION PATIENTS ONLY

INSURANCE CO: ____ ADJUSTOR: ___________________________________

ADDRESS: ____ PHONE #: _____________________________________

____ FAX#: ____
CITY STATE ZIP CODE

CLAIM#: __________________________________ DOI: ________________________ CMPSBL INJURY:________________________

PRE-CERTIFICATION COMPANY: ____ PHONE: ___________________________________

FAX #: _______________________________________ NO. OF VISITS APPROVED: ______________ CONSULT ONLY

HEALTH INSURANCE INFORMATION:

PRIMARY CARRIER: ____ SUBSCRIBER: ______________________________________

ID#: __________________________________ GROUP#: ___________________________ RELATION TO PATIENT: _________________

SUBSCRIBER SOCIAL SECURITY#:____ DOB: ______________________________________

SECONDARY CARRIER: ____ SUBSCRIBER:______________________________________

ID#: __________________________________ GROUP#: ___________________________ RELATION TO PATIENT: _________________

SUBSCRIBER SOCIAL SECURITY#:____ DOB: ______________________________________

EMERGENCY CONTACT: ____ **PHONE#:** ____

INSURANCE AUTHORIZATION: I hereby authorize STOSSA to furnish information to my insurance carriers concerning my illness and treatment.

ASSIGNMENT OF BENEFITS: I hereby assign to STOSSA all payment for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance within 30 days of the statement date. Co-payment is expected at the time services are rendered.

DATE: _____________________________________ **SIGNATURE**: ____