Center for Orthopaedic Surgery and Sports Medicine

7940 FLOYD CURL DRIVE SUITE 560 • SAN ANTONIO, TX 78229
PHONE: (210) 692-7400 • FAX: (210) 692-0090

Account Number: _____ **Date:** _____

Patient Information

Name: Last First MI		Social Security Number	Drivers License Number
Street Address		Employer	
City State Zip		Street Address	
Home Phone Number		City State Zip	
Date of Birth	Age	Work Phone Number	Occupation
Sex M/F	Marital Status	In Case of Emergency, Notify: Name: Phone:	

Who referred you to our office? (Full Name) _____
Are you allergic to any medication? (Please list) _____
Primary Care Physician (Full Name) _____ Phone Number _____
Briefly discuss the symptoms for which you are seeking treatment. Please give part of body involved. _____
_____
_____
_____

Accident Information

Is your condition the result of an accident or injury? ☐ Yes ☐ No Date of Accident/Injury _____
Was your injury the result of: ☐ Job Injury ☐ Auto Accident ☐ Other _____
Is there an attorney involved in your health claim? ☐ Yes ☐ No
Attorney Name _____ Address _____ Phone _____

Insurance

Name of Insured: _____ **Date of Birth:** _____ **SS#** _____

PRIMARY INSURANCE	*SECONDARY INSURANCE*	*WORKERS COMPENSATION*
Insurance Company	Insurance Company	Insurance Company
Street Address	Street Address	Mail-Claim Attention
City/State/Zip	City/State/Zip	Street Address
Telephone	Telephone	City/State/Zip
Insured Name/Relationship	Insured Name/Relationship	File/Claim/Number
Employer of Insured	Employer of Insured	Telephone
Employer Address	Employer Address	Date of Injury
Policy/ID Number	Policy/ID Number	Nature of Injury
Group Number	Group Number	Services Approved

Assignment to pay beneifts to physician: _____ I hereby assign, transfer, and set over to Dr. Ty H. Goletz all rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company or companies. I understand that this authorization does not release me from my personal responsibility for payment of all charges within 30 days. I also authorize this physician to release any information necessary for payment of medical claims.

Signature: _____ **Date:** _____