TEXAS ORTHOPAEDIC
ASSOCIATES
A DIVISION OF OrthoLoneStar

PATIENT INFORMATION FORM

Patient Information:

Last Name: ______________________________

First Name: __________________ Middle Initial: ___

Preferred Name: ___________________________

Date of Birth: ____ / ____ / _____ Age: _____

SSN: _____-_____-_____ Sex: [ ] Female [ ] Male

Address: _____________________ Apt #: ________

City: _____________ State: _______ Zip: ________

Email Address: ____________________________

Home #: ______________ Cell #: ______________

Employer: ________________________________

Address: _______________________ Suite: _____

City: _______________ State: _____ Zip: _______

Work #: ______________

Preferred Method of Contact:

Home__ Work__ Cell__ Email__ Text__

Emergency Contact / Other Parent Information (If patient is a minor)

Last Name: ___________ First Name: ___________

Relationship: ______________ D.O.B.: ___________

Home #: _____________ Cell #: _______________

Work #: _____________

Email Address: ____________________________

Policy Holder (If not patient):

Last Name: ________________________________

First Name: ________________________________

Relationship: _______________________________

Date of Birth: ____ / ____ / ____ SSN: _____-_____-_____

Address: ________________________ Apt #: _____

City: ______________ State: _____ Zip: _________

Home #: ______________ Cell #: ______________

Work #: ______________

Employer: ___________________________________

Address: ________________________ Suite: _____

City: _________________ State: _____ Zip: _______

Insurance Information:

Primary

Insurance Company Name: ____________________

Phone #: ______________

Policy Holder Legal Name: ____________________

ID #: _______________ Group #: _______________

Secondary

Insurance Company Name: ____________________

Phone #: ______________

Policy Holder Legal Name: ____________________

ID #: _______________ Group #: _______________

Consent to text: ❒ Yes ❒ No

Language: ❒ English ❒ Spanish ❒ Other: ________________

Race: ❒ African American ❒ American Indian or Alaska Native ❒ Asian ❒ Black ❒ Black or African ❒ Mexican American Indian ❒ Native Hawaiian or Other Pacific Islander ❒ Other Race ❒ White

Ethnicity: ❒ Central American ❒ Cuban r Dominican ❒ Hispanic or Latino Spanish ❒ Latin American or Latin Latino ❒ Mexican ❒ Not Hispanic or Latino ❒ Puerto Rican ❒ South American r Spaniard

Marital Status: ❒ Unknown ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widowed ❒ Partner

[ ] Please sign below to acknowledge all information above is correct.

Signature: ____ **Date:** ____________