



IRVING ORTHOPEDICS & SPORTS MEDICINE SOUTHWEST SPINE INSTITUTE

Please PRINT AND complete All sections below!

Is your condition a result of work injury? YES NO An auto accident? YES NO Date of injury _____

PATIENT'S INFORMATION

Marital Status: Single Married Divorced Widowed Sex: Mal Female

Name: _____
last name first name initial

Street address: _____ (Apt# _____) City: _____ State: _____ Zip: _____

Home phone:(____) _____ Work phone:(____) _____ Mobile phone:(____) _____

Date of Birth: ____/____/____ Driver's Lic.:(state & #) _____ Social Security # _____
month day year

Employer Name: _____ Full Time Part Time

Spouse's Name: _____ Spouse's Work Phone:(____) _____
last name first name initial

RESPONSIBLE PARTY INFORMATION

If different than patient.

Responsible party: _____ Date of Birth: ____/____/____
month day year

Relationship to Patient: Self Spouse Other _____ Social Security # _____

Responsible Party's Home phone:(____) _____ Work Phone:(____) _____

Address : _____ (Apt# _____) City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone Number:(____) _____

Address: _____ City: _____ State: _____ Zip: _____

Your Occupation: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Company's Name : _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Other Child

Insurance ID Number: _____ Group Number: _____

SECONDARY Insurance Company's Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Other Child

Insurance ID Number: _____ Group Number: _____

PATIENT'S REFERRAL INFORMATION

Name of Physician that referred you: _____

PCP Name (If different than Referring Physician): _____

Assignment of benefits * Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Irving Orthopedics and Sports Medicine, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Method of Payment: Cash Check Credit Card

AR 32103

Form Continued on Reverse Side

PATIENT REGISTRATION

Please PRINT AND complete ALL sections below !

EMERGENCY CONTACT

Name of Person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone:(____) _____ Work phone:(____) _____ Mobile phone:(____) _____

PHARMACY PREFERENCE

Name: _____ Phone: _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birthdate: _____
Signature: _____ Date: _____

IOSM FACSIMILE AUTHORIZATION FORM

I, the undersigned, authorizes IOSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories and other medical caregivers in the necessary coordination of care for the patient listed below.

I may revoke this authorization by giving IOSM five (5) days written notice. This revocation may be by facsimile transmission, however a **written copy of the revocation must be mailed to IOSM as well.**

Patient Name: _____
Patient Signature: _____

CONTACT AUTHORIZATION

Circle where you can be reached during business hours: Home Work Cell

May we contact you at home? Yes No

May we contact you at your place of business? Yes No

Leave message with:

Leave message with:

Yes No Voicemail / Answer Machine

Yes No Voicemail / Answer Machine

Yes No Mobile Phone

Yes No Mobile Phone

Yes No Family Member

Yes No Co-Worker

May we contact you via email? Yes No E-mail Address: _____

Patient Signature: _____

I hereby give permission to Irving Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following members (relatives, or close personal friends):

Name

Relationship

Name

Relationship

Name

Relationship

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions.