Austin Orthopedics and Sports Medicine

Please fill in all of the following confidential information

Patient Name: _____

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

Address:_____ Apt# _____
(Please add a physical address along with any PO Boxes listed)

City _____State _____Zip _____

Marital Status (please circle): Married Single Minor Other _____

Sex (please circle): Male Female

Phone Numbers:

Home Number _____ Work Number_____
Cell Number _____ Pager Number _____

Email Address: _____

Emergency Contact: _____ (relationship) _____
Home # _____Cell # _____ Work # _____

Insurance Subscriber Information **or** **(check) if same as above _____**

Name: _____
Date of Birth: _____SS#_____
Address: _____
Employer: _____ Phone # _____
Relationship to patient (please circle): self spouse parent guardian

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician, and that I am financially responsible for any balance(s). I also authorize Austin Orthopedics and Sports Medicine or insurance company to release any information required to process my claims.

Signature: _____ Date: _____