

# GREATER AUSTIN ORTHOPAEDICS

## PATIENT INFORMATION SHEET (PLEASE COMPLETE IN FULL)

### Patient Information:

Name: \_\_\_\_\_  
(Last) (First) (Middle)

DOB: \_\_\_\_\_ Sex (Check One):  Male  Female  Other SSN: \_\_\_\_\_

Race:  American Indian/Alaska Native  Asian  Black/African American  Decline  
 Nat Hawaiian/Pacific Islander  White  Other  Unknown

Marital Status:  Single  Married  Partnered  Divorced  Widowed

Drivers License: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Religion:  Buddhist  Catholic  Hindu  Islam  Jewish  Protestant  Other  Unknown

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of **Spouse** or **Guardian** (Circle One): \_\_\_\_\_

Spouse/Guardian DOB: \_\_\_\_\_ Spouse/Guardian SSN: \_\_\_\_\_

Employer of Spouse/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Emergency Contact Information:

Emergency Contact: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Emergency Contact DOB: \_\_\_\_\_ Primary Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

### Insurance Information:

**Date of Injury:** \_\_\_\_\_ **Work Related?** (Check One):  No  Yes

**Primary Insurance Co:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Claims Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Name of Policyholder:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group:** \_\_\_\_\_

**DOB of Policyholder:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Policyholder's Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Secondary Insurance Co:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Claims Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Name of Policyholder:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group:** \_\_\_\_\_

**DOB of Policyholder:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Policyholder's Employer:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### How were you referred to Greater Austin Orthopaedics?

**Primary Care Physician:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Insurance Company:** \_\_\_\_\_

**Other:** \_\_\_\_\_

# GREATER AUSTIN ORTHOPAEDICS

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(PLEASE COMPLETE IN FULL)

**Authorization:**

Financial Responsibility, Assignment of Benefits, Authorization to Release Information:

I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representative, or referring physician at such time as information is requested. I authorize assignment of benefits to my physician.

Additionally, I give my permission to Greater Austin Orthopaedics and staff to release medical information contained in my medical file about myself to those indicated below.

Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Consent For Treatment:

I do hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Date

**Please visit [www.gaortho.com](http://www.gaortho.com) to fill out a patient survey.**