



NORTH TEXAS SPINAL INSTITUTE AT ALL-STAR ORTHOPAEDICS

Spinal Surgery and Reconstruction

Patient Legal Name: _____
Last First Middle Preferred Name

Address: _____ Home #: () _____
Street Apartment #

City _____ State _____ Zip Code _____ Date of Birth: _____ Age: _____

Social Security #: _____ Drivers Lic. #: _____ Marital Status: S M D W Sex: F / M

Email Address _____

Employer: _____ Work #: () _____
Company Name

Address: _____
Street Suite # City State Zip Code

Guarantor (if patient is a minor) or Spouse Information or Emergency Contact

Name: _____ Relationship: _____
Last First Middle

DOB: _____ SSN: _____ Home #: () _____ Marital Status: S M D W

Address: _____
Street Apartment # City State Zip Code

Employer: _____ Work #: () _____

Address: _____
Street Suite # City State Zip Code

Family Doctor/PCP: _____ Phone #: () _____ Referred By: _____

Insurance Primary: _____ Phone #: () _____
Insurance Name

Policy Holder's Name _____ ID#: _____ Group #: _____

Secondary: _____ Phone #: () _____
Insurance Name

Policy Holder's Name _____ ID#: _____ Group #: _____

HMO
PPO
IN

Information Regarding Medical Problem **Date of Injury / Onset:** _____

Result of Accident? Y N Injured on the Job? Y* N In Automobile Accident? Y N

* If YES, Tell Receptionist

Please Circle: Right / Left Finger Hand Wrist Arm Shoulder Elbow Back/Neck Hip Leg Knee Foot Ankle Toe

How did injury occur? Include location where it happened. _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS
 I authorize Las Colinas Orthopedic Surgery and Sports Medicine to release to my insurance company any information acquired in the course of my care and permit payment directly to Las Colinas Orthopedic Surgery and Sports Medicine for any benefits due for services rendered. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits.

 Patient / Guardian Signature Date