Orthopaedic Surgery & Sports Medicine
OF SAN ANTONIO

Current Visit / Insurance Patient Form

Today's Date_____

Patient Name: _____
Last Middle First

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____Ext____

DOB: _____ Gender: □Male □ Female Social Security # _____

Email Address: _____ Primary Source of Contact: □Home □Phone □Cell Phone □Email

Drivers License # _____Employer: _____ Work Phone: _____

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

Who may we call in Case of Emergency? Name: _____

Relationship to patient: _____ Primary Phone #: _____

Secondary Phone #:_____

Referring Physician: _____ Physician Phone Number: _____

Collection Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Once a balance reaches 90 days old without payment, it will be transferred to a third party for further collections or other actions. There will be a charge for filling out forms that require more than a signature and $20.00 for writing letters each time these services are provided.

Canceling/Rescheduling An Appointment: If you are unable to keep your appointment, please notify our office at least twenty-four hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients needing exams the option to use your scheduled appointment time. Patients will be charged $25 for missed appointments unless the appointment was cancelled 24 or more hours in advance. Worker's Compensation patients will be personally responsible for this amount.

Patient's Initials _____

Primary Insurance Co.: _____Insurance Phone: _____

Insured Name: _____ DOB: _____ SS#: _____

Patient Relationship to Insured: _____

Insurance ID#:_____Group#:_____

***Secondary Insurance Co.:** _____ Insurance Phone: _____

Insured Name: _____ DOB: _____ SS#:_____

Patient Relationship to Insured: _____ Insurance ID# _____Group# _____