



TRINITY ORTHOPEDICS

809 W. Harwood Rd, Suite 101 Hurst, Texas 76054
817-283-5252 Fax: 817-283-5283
www.trinityorthopedics.com

Instructions: All sections must be completed. If not applicable, please indicate as "N/A."

Was this injury sustained on the job? Yes No Was this a result of a car accident? Yes No

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M.I. _____ Nickname _____ MALE FEMALE

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

Date of Birth ___/___/___ Age ___ Social Security# ___-___-___ Marital Status: Single Married Widowed Divorced

Home Phone(____)____-____ Work Phone: (____)____-____ Cell Phone:(____)____-____

Employer/School Name _____ Employed: Full Time Part Time Student: Full Time Part Time

Employer/School Address _____ City: _____ State: _____ Zip: _____ Phone:(____)____-____

Driver's License# _____ State License Issued _____ Primary Care Physicians Name: _____

Email: _____

EMERGENCY CONTACT:

Primary Contact: _____ Relationship: _____ Phone (____)____-____ Hm Wk Cell

Secondary Contact: _____ Relationship: _____ Phone (____)____-____ Hm Wk Cell

REFERRED BY:

Doctor: _____ Clinic: _____ Patient: _____
Family Member: _____ HMO/PPO: Directory _____ Employer _____
Print Advertising _____ Internet: _____ School: _____
Other: _____

Primary Insurance:

(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name: _____

Male Female Date Of Birth: ___/___/___

Social Security# ___-___-___

Patient's Relationship to Subscriber: _____

Employer: _____

Employers Address: _____

City: _____ State: _____ Zip: _____

Insurance Co Name: _____

Phone:(____)____-____

Claims Filing Address: _____

City: _____ State: _____ Zip: _____

Identification # _____ Group# _____

Secondary Insurance:

(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name: _____

Male Female Date Of Birth: ___/___/___

Social Security# ___-___-___

Patient's Relationship to Subscriber: _____

Employer: _____

Employers Address: _____

City: _____ State: _____ Zip: _____

Insurance Co Name: _____

Phone:(____)____

Claims Filing Address: _____

City: _____ State: _____ Zip: _____

Identification # _____ Group# _____

Guarantor

Last Name: _____ First: _____ M.I. _____ Male Female
Date of Birth: ____/____/____ SS# ____-____-____ Driver's License # _____ State License Issued ____
Relationship to patient: _____
Address: _____ City _____ State _____ Zip: _____
Home Phone(____) _____ - _____ Work Phone:(____) _____ - _____ Cell:(____) _____ - _____

Have you ever been treated by one of the physicians at Trinity Orthopedics. No Yes
If yes, which Physician: _____ Approximate date ____/____/____

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

FINANCIAL RESPONSIBILITY: I acknowledge full financial responsibility for services rendered. I also understand that payment of charge incurred is due at time of services. I am ultimately responsible for all medical payments.

AUTHORIZATION TO RELEASE INFORMATION: I hereby understand and acknowledge I have been provided with a Notice of Privacy Practices. I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to TRINITY ORTHOPEDICS P.A I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature (Patient, Parent, or guardian) _____ Print Name: _____

Date: _____ Relationship: _____