



Welcome to North Texas Orthopaedic & Spine
4510 Medical Center Drive, Suite 312
McKinney, Texas 75069

Name: _____ Today's Date: _____
First Middle Last

How did you learn about our practice? _____

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Date of Birth: _____ Age: _____ Email Address: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
In case of emergency, contact: _____ Relationship: _____
Home Phone: () _____ Work Phone: () _____

[Primary Insurance]

Name of Insurance Company: _____
Insured's Name: _____ Relationship to insured _____
Insured's date of birth _____ Insured's SSN _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]

Name of Insurance Company: _____
Insured's Name: _____ Relationship to insured _____
Insured's date of birth _____ Insured's SSN _____
Group Number: _____ Policy ID Number: _____

I do not have insurance and will be paying my charges in full today.

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No
Ins/Workers Comp Carrier _____ Claim # _____
Case Manager: _____ Contact Phone # _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers.
Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Signature of Patient or Responsible Party: _____ Date: _____

I authorize the release of any medical information necessary to process my claim.
Signed: _____
(Patient or responsible party)

I authorize payment of medical and surgical benefits to _____, MD.
Signed: _____
(Patient or responsible party)