OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

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PATIENT INFORMATION

(Please Print - Fill In All Blanks)

PATIENT'S LEGAL NAME: LAST | FIRST | MIDDLE INITIAL | SEX | BIRTH DATE | AGE

SOCIAL SECURITY NO.: | E-MAIL ADDRESS: | MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

PATIENT'S ADDRESS: | Are You: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Not Employed ☐ Disabled

CITY: | STATE: | ZIP CODE: | PATIENT EMPLOYER:

HOME PHONE: ( ) | WORK PHONE: ( ) | CELL PHONE: ( ) | Is it okay to leave a message on phone number provided? ☐ Yes ☐ No

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

All policy holder informationmust be filled out completely in order to file your insurance.

Primary Insurance Company ____________________ Policy Holder ____________________

Employer____________________ SS# ____________________ DOB ____________________

Secondary Insurance Company ____________________Policy Holder ____________________

Employer____________________ SS# ____________________ DOB ____________________

Tertiary Insurance Company ____________________ Policy Holder ____________________

Employer____________________ SS# ____________________ DOB ____________________

PERSON RESPONSIBLE FOR BILL

Name ____________________ DOB ____________________ SS# ____________________

Address____________________ Phone# ____________________
(If different than patient)

WORK COMP / MVA Information -

Please note that if you answer yes to any of the following questions, we must have all the information prior to your appointment.

Is your injury work related? ☐ Yes ☐ No

Has a claim already been filed? ☐ Yes ☐ No

Is your injury due to a motor vehicle accident? ☐ Yes ☐ No

EMERGENCY CONTACT

HOME PHONE: | RELATIONSHIP TO THE PATIENT

I hereby authorize any insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims.
I acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature | Date

Form 100