4444 Heritage Trace, Suite 408. Keller, Texas 76244
817-283-5252, Fax: 817-283-5253
www.trinityspineortho.com

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

PATIENT INFORMATION

Last Name: ______________________________ First Name: ______________________________ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: ____ City: ______________________ State: ____ Zip: ___________

Date of Birth: _____/_____/_____ Age: ___ Social Security #: _____-_____-______ Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Home Phone: ( ) ________________ Cell Phone: ( ) ________________ E-mail Address: ______________________________

Race: __________________ Ethnicity: ❑ Latino ❑ Hispanic Preferred Language: ❑ English ❑ Spanish ❑ Other

Employer/School Name: ______________________________ Employed: ❑ Full Time ❑ Part Time Student: ❑ Full Time ❑ Part Time

Employer/School Address: ______________________ City: ______________ State: ___ Zip: _____ Phone: ( ) _____________

Driver's License #: _________________ State Issued: ____ Primary Care Physician's Name: ___________________________________

Pharmacy Name: ____ Pharmacy Phone: ( ) ______________________

EMERGENCY CONTACT

Name: ______________________________ Relationship: ______________ Phone: ( ) _________________ ❑ Home ❑ Work ❑ Cell

REFERRED BY

Doctor: _____________________________ Clinic: ______________________________ Patient: ______________________________

Family Member: ______________________ HMO/PPO: Directory __________________ Employer: ____________________________

Print Advertising: _____________________ Internet: ____________________________ School: ______________________________

____Yes ____No Is this injury the result of a Motor Vehicle Accident?

____Yes ____No Were You Injured on the job?

If yes, have you filed a Worker's Comp Claim? ____Yes ___ No

____ Yes ____No Do you have Medicaid?

____ Yes ____No Have you had surgery in the last 90 days?

If yes, who was the Doctor? __________________________________

If yes, what was the procedure? _______________________________

____ Yes ____No Are you prepared to pay your portion today?

Signed____ Date _______________

Revised 03/2014

4444 Heritage Trace, Suite 408. Keller, Texas 76244
817-283-5252, Fax: 817-283-5253
www.trinityspineortho.com

Patient Name: ____ Date: __________________

PRIMARY INSURANCE	SECONDARY INSURANCE
(Please complete blanks with subscribers/primary insurance holders information)	(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name: _____________________________________	Subscribers Name: _____________________________________
❑ Male ❑ Female Date of Birth: ______/______/_________	❑ Male ❑ Female Date of Birth: ______/______/_________
Social Security #: _______________________________________	Social Security #: _______________________________________
Patient's Relationship to Subscriber: ________________________	Patient's Relationship to Subscriber: ________________________
Employer: ____	Employer: ____
Employers Address: ____________________________________	Employers Address: ____________________________________
City: ______________________ State: _____ Zip: ___________	City: ______________________ State: _____ Zip: ___________
Insurance Co. Name: ____________________________________	Insurance Co. Name: ____________________________________

GUARANTOR

❑ Patient Is Guarantor

Last Name: ______________________________ First Name: ______________________________ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: ____ City: ______________________ State: ____ Zip: ___________

Date of Birth: _____/_____/_____ Social Security #: _____-_____-______ Driver's Licence #: ________________ State Issued _______

Home Phone: (   ) ___________________ Work Phone: (   ) ___________________ Cell Phone: (   ) ___________________

Relationship to Patient: __________________ Have you ever been treated by one of the physicians at Trinity Spine & Ortho: ❑ Yes ❑ No

If Yes, which physician: _______________________________________ Approximate Date: __________________________________