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San Antonio, TX 78233 (Main Location)  
210-477-5151  
Fax: 477-5152



NORTHEAST ORTHOPAEDICS  
& SPORTS MEDICINE, LLP

8715 Village Dr. #120  
San Antonio, TX 78217  
210-477-5151  
Fax: 477-5152

*Please Print* Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Male/Female

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home PH: \_\_\_\_\_ Work PH: \_\_\_\_\_ Cell PH: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Marital Status: M - D - S - W

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Guarantor (If Pt is a Minor) \_\_\_\_\_ Employer: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Cell PH: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred By Whom: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

INSURANCE INFORMATION

*Please Provide Insurance Card(s) and Photo ID to the Receptionist for Copies to be Made*

Insured's Name: (If different from patient) \_\_\_\_\_

Referred By Whom: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Insured's DOB & SS#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

MEDICAL INFORMATION

Is this a Work-Related Injury? \_\_\_\_\_ If Yes, see the Receptionist \_\_\_\_\_

What are you being seen for today? \_\_\_\_\_ If due to accident, type and date occurred: \_\_\_\_\_

Is this related to an auto accident? \_\_\_\_\_ Date of accident: \_\_\_\_\_

*I certify the above information is correct. I authorize David L. Fox, MD, Ples L. Kujawa, MD, Brian E. Schulze, MD, Scott L. Sledge, MD, Rex E. Wilcox, MD, Melissa Bachman, PA, Ashley Book, PA, Kelly Cooper, PA, or Matthew Froman, PA of Northeast Orthopaedics, LLP to release or request medical information necessary to process health insurance claims. I authorize payment of my medical insurance benefits to Northeast Orthopaedics LLP. I understand that I will be responsible for payment at the time services are rendered. This includes any outstanding deductible and/or coinsurance. Our office does not file third party claims. Payment is expected in full, Northeast Orthopaedics LLP will provide itemized receipts for services provided for reimbursement of third-party billing.*

\_\_\_\_\_ Patient Signature \_\_\_\_\_ Staff Witness Signature

If you are referred to Sendero or Physicians Ambulatory Surgery Center, we are required by law to inform you that Northeast Orthopaedics & Sports Medicine physicians have ownership interest in those facilities and may receive remunerations indirectly for services rendered.