

**TEXAS CENTER FOR JOINT REPLACEMENT**

**PATIENT INFORMATION**

Nickname: \_\_\_\_\_

Name \_\_\_\_\_ M.I. \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (hm) (\_\_\_\_\_) \_\_\_\_\_ (wk) (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Email address : \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

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

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse or Next of Kin Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number \_\_\_\_\_

Phone (hm) (\_\_\_\_\_) \_\_\_\_\_ (wk) (\_\_\_\_\_) \_\_\_\_\_

**Emergency Contact Information (OUTSIDE OF YOUR HOME)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (hm) (\_\_\_\_\_) \_\_\_\_\_ (wk) (\_\_\_\_\_) \_\_\_\_\_

**Primary Care Physician (PCP) Information**

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Referring Information: (circle one & complete below) Physician, Family or Friend?**

Name \_\_\_\_\_ Dr. Specialty \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Information**

**Primary**

**Secondary**

Insurance Name \_\_\_\_\_

\_\_\_\_\_

Claims Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

\_\_\_\_\_

Policy Number \_\_\_\_\_

\_\_\_\_\_

Group Number \_\_\_\_\_

\_\_\_\_\_

Group Number \_\_\_\_\_

\_\_\_\_\_

Employer's Name \_\_\_\_\_

\_\_\_\_\_

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I authorize payment of medical benefits to **TEXAS CENTER FOR JOINT REPLACEMENT** for services rendered. I understand I am financially responsible for all charges whether or not covered by insurance.

Signature \_\_\_\_\_

Date \_\_\_\_\_