



Elliott I. Clemence, M.D.

South Texas Center For Orthopaedics

Welcome To Our Office

Please Fill Out Form Completely

PLEASE PRINT

Patient Registration Information

Name: Soc. Sec. #: Birthdate: Address: Home Phone: Cell Phone: City: State: Zip: Sex: Male / Female Marital Status S M D W Employer: Business Phone: Business Address: Occupation: In case of emergency, who should we contact? Relationship To You: Phone: Reason For Visit: Accident Auto Accident Sports Injury Job Injury Other Date of Injury: Is This Workmans' Comp? Yes No Was this reported to your company? Yes No Describe how injury happened:

\* Who should we thank for referring you to our office? Family Doctor: Do you have an attorney? If yes, name and address:

Primary Insurance Person Responsible for Account: Relation: Self Spouse Other Birthday: Soc. Sec. # Insurance Company: Address: Subscriber I.D. #: Group #:

Additional Insurance Person Responsible for Account: Relation: Self Spouse Other Birthday: Soc. Sec. # Insurance Company: Address: Subscriber I.D. #: Group #:

Have you ever had any of the following: (Please check appropriate box) Heart Disease Congestive Heart Disease Asthma Diabetes Previous Fracture High Blood Pressure AIDS or HIV Infection Cancer Epilepsy Blood Disease Rheumatic Fever Thyroid Disease Heart Murmur Tuberculosis Liver Disease Kidney Disease Lung Disease Major Operation

Do you have any other health or medical information you think that I should know about? Have you, within the past two years been under the care of a doctor? Dr's Name: What for? When? Date of Last Visit? Are you allergic to any drug or medicine? Yes No If so, what are they? Have you taken any drugs or medicine the last six months besides Aspirin? Yes No If so, what? If female, are you or is there a possibility of you being pregnant? Yes No Unknown

Assignment and Release

I hereby authorize directly to Dr. Elliott I. Clemence of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: Date: