J. ANDREW HURST, M.D.
PINEY WOODS ORTHOPEDICS
3816 NORTH UNIVERSITY
NACOGDOCHES, TEXAS 75965

PATIENT INFORMATON

DATE: ___________________

PATIENT'S NAME: ____ AGE: _______ SEX : M ( ) F ( )

DATE OF BIRTH: ____________________________ SOCIAL SECURITY #: ____

ADDRESS: ____
STREET CITY, STATE ZIP CODE

HOME PHONE: ( )______________________________ CELL PHONE : ( )__________________________________

CIRCLE MARITAL STATUS: M S D W email____________________________________

PHARMACY (To be used for Prescriptions) ____

RACE ________________ ETHINTICITY: HISPANIC_______ NON HISPANIC_______ LANGUAGE_______________

PATIENT'S EMPLOYER INFORMATION

EMPLOYER: ____ OCCUPATION: ________________________________

EMPLOYMENT STATUS: FULL TIME ( ) PART-TIME ( ) SELF ( ) RETIRED ( ) ACTIVE MILITARY ( )

EMPLOYER ADDRESS: ____ PHONE : ( ) __________ EXT. ____
STREET CITY/ST ZIP CODE

PATIENT'S SPOUSE INFORMATION

SPOUSE'S NAME: ____ OCCUPATION: _________________________________

SPOUSE'S SOCIAL SECURITY#: ______________________________ SPOUSE'S DATE OF BIRTH: ______________________

SPOUSE'S EMPLOYER: _______________________________________ PHONE: ( )____________________ EXT. ________

ACCIDENT/ILLNESS INFORMATION

COMPLETE DATE OF ACCIDENT: ____

WERE YOU INJURED: ON THE JOB ( ) AUTO ACCIDENT ( ) SCHOOL INJURY ( ) OTHER ( )

BRIEFLY DESCRIDE ACCIDENT: ____

IF NOT AN ACCIDENT, GIVE DATE OF FIRST SYMPTOM: ____

HAVE YOU HAD THIS SAME OR SIMULAR ILLNESS? YES ( ) NO ( )

IF YES, PLEASE DESCRIBE: ____
____

***WE DO NOT FILE LIABILITY CLAIMS. UPON PAYMENT A RECEIPT WILL BE PROVIDED SO YOU CAN**

FILE FOR REIMBURSEMENT. IF YOU HAVE ANY QUESTIONS PLEASE SPEAK WITH THE FRONT DESK.

OTHER PATIENT INFORMATION

PERSONAL /FAMILY PHYSICIAN: ________________________________ REFERRED BY: ____________________________

PARENT / GUARDIAN INFORMATION

PLEASE COMPLETE THIS SECTION IF YOU ARE A COLLEGE STUDENT OR UNDER 21 YRS OLD

FATHER'S NAME: ____ OCCUPATION: _____________________________

EMPLOYER: ____ PHONE ( ) : __________________ EXT. _____

MOTHER'S NAME: ____ OCCUPATION: _____________________________

EMPLOYER: ____ PHONE ( ): ____________________ EXT. _____

PARENT'S HOME ADDRESS: ____

STREET CITY/STATE ZIP CODE

PARENT'S HOME PHONE: ( ): __________________

PLEASE COMPLETE THE INSURED'S INFORMATION BELOW

INSURED = PERSON WHO CARRIES THE INSURANCE IN THEIR NAME

INSURED'S NAME: ____ RELATION TO PATIENT: ________________________

INSURED'S DATE OF BIRTH: ___________________ INSURED'S SOCIAL SECURITY #: ___________________________

INSURED'S EMPLOYMENT STATUS: FULL TIME ( ) PART TIME ( ) RETIRED ( )

INSURED'S EMPLOYER: ____

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. J. Andrew Hurst to release any information acquired in the course of my examination/treatment to my insurance carrier. I also authorize Dr. Hurst to release information to any hospital and physician I may be referred to by this office. In work- related injury cases, I authorize Dr. Hurst to release information to my employer.

MEDICARE / MEDICAID / SECONDARY INSURANCE ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dr. J. Andrew Hurst for all medical services rendered.

OFFICE POLICY / ASSIGNMENT OF BENEFITS REGARDING PRIVATE INSURANCE AND PRIVATE PAY: If my funding is private insurance or private pay, then payment is expected at time of service, unless prior arrangements have been made. I understand filing my insurance is a courtesy, and I am responsible for all costs of treatment including those of charges that exceed or are not covered by my insurance. On assigned claims, I hereby authorize payment directly to Dr. J. Andrew Hurst for medical services rendered. I have read and understand the above statements. I agree to comply with the financial policies of this office.

SIGNATURE: (PATIENT, PARENT, OR GUARDIAN): ______________________________________ **DATE:** _____________