

# TRI COUNTY ORTHOPEDIC SURGEONS, INC.

DATE \_\_\_\_\_

## Patient Profile

Patient Name		Home Phone	Cell Phone	Employer and Phone #
Mailing Address			Family Doctor Name and Phone Number	
City, State, Zip			Referring Doctor Name and Phone Number	
Age	Date of Birth	Social Security	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	

### SPOUSE/PARENT/GUARDIAN INFORMATION (Please circle which one)

Name	Social Security #	Date of Birth	Relationship to Pt	Phone #
Mailing Address				
Occupation		Employer		

### EMERGENCY CONTACT

Name	Relationship	Phone #
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### INSURANCE INFORMATION Please present your insurance cards so that we may obtain a copy for our records.

Primary Insurance Company			Secondary Insurance Company		
Policy Holder's Name		Policy ID Number	Policy Holder's Name		Policy ID Number
Date of Birth	Co-Pay	Relationship to Patient	Date of Birth	Co-Pay	Relationship to Patient
Policy Holder's Address			Family Doctor Name and Phone Number		
Policy Holder's Employer			Policy Holder's Employer		
If BWC: Date of Injury	Claim Number		Employer at Time of Injury		Physician of Record
I authorize Tri County Ortho Surgeons to leave a message at (please initial all that apply) _____HOME    _____WORK    _____CELL					

**Race:**

- White/Caucasian
- Black or African
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Asian
- Hispanic or Latino

**Ethnicity:**

- Latino or Hispanic
- Not Latino or Hispanic

**Language:**

- English
- Spanish
- Indian
- Other

PHARMACY NAME	Location	Phone Number
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