

# TRI COUNTY ORTHOPEDIC SURGEONS, INC.

DATE \_\_\_\_\_

## Patient Profile

Patient Name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	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	Phone #
Mailing Address				
Occupation	Employer	Phone		

### 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	Policy Holder's Name		Policy Id
Date of Birth	Co-Pay	Relationship to Patient	Date of Birth	Co-Pay	Relationship to Patient
Policy Holder's Address			Policy Holder's Address		
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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