

**TENNESSEE ORTHOPAEDIC CLINICS, P.C.**  
**Patient Information Sheet**

Date: \_\_\_\_\_ DOCTOR YOU ARE SEEING: \_\_\_\_\_ CHART #: \_\_\_\_\_

HAVE YOU BEEN SEEN IN OUR OFFICE BEFORE? <input type="checkbox"/> YES WHEN? _____ <input type="checkbox"/> NO BY WHOM? _____			
PATIENT'S FULL NAME (FIRST)		(MIDDLE)	(LAST)
ADDRESS		CITY	STATE ZIP
HOME PHONE # ( )	SOCIAL SECURITY #	PT SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER			
EMAIL ADDRESS			
EMPLOYER	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	WORK PHONE #	OCCUPATION
EMPLOYER'S ADDRESS		IS PATIENT A STUDENT? FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE? _____
SPOUSE'S NAME (FIRST)	(MIDDLE)	SPOUSE'S EMPLOYER	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
WORK PHONE #			PHONE #
EMERGENCY CONTACT PERSON OR NEXT OF KIN - (NOT LIVING WITH YOU)		ADDRESS	PHONE #
<b>INFORMATION ABOUT ILLNESS OR INJURY:</b>			
WAS INJURY CAUSED BY ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____	INJURY OCCURRED <input type="checkbox"/> DUE TO AUTO ACCIDENT <input type="checkbox"/> ON THE JOB <input type="checkbox"/> OTHER	STATE WHERE AUTO ACCIDENT OCCURRED?	DATE OF FIRST SYMPTOMS
PATIENT SEEN IN EMERGENCY ROOM? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____	WHICH HOSPITAL	HOW DID YOU HEAR ABOUT OUR OFFICE? (If other than physician referral)	
BODY PART TO BE EXAMINED/COMPLAINT	NAME OF PHYSICIAN WHO REFERRED YOU TO OUR OFFICE (FIRST) _____ (LAST) _____	<input type="checkbox"/> FAMILY/FRIEND <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> INS. CO. <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> ATTORNEY <input type="checkbox"/> RADIO <input type="checkbox"/> EMPLOYER <input type="checkbox"/> OTHER _____	
REFERRING PHYSICIAN'S ADDRESS		REFERRING PHYSICIAN'S PHONE	
NAME OF PRIMARY CARE PHYSICIAN (FIRST) _____ (LAST) _____			
<b>GUARANTOR NAME (RESPONSIBLE FOR PAYMENT:</b>	(CHECK) <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> EMPLOYER <input type="checkbox"/> OTHER		
FULL NAME (FIRST) _____ (MIDDLE) _____ (LAST) _____	HOME PHONE # _____ ( )	DATE OF BIRTH	SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP
EMPLOYER	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	WORK PHONE #	OCCUPATION
EMPLOYER'S ADDRESS			

PATIENT/GUARDIAN SIGNATURE _____		DATE _____	
<input type="checkbox"/> <b>PRIMARY INSURANCE</b>		<input type="checkbox"/> <b>SECONDARY INSURANCE</b>	
INSURANCE COMPANY NAME	TYPE OF PLAN	INSURANCE COMPANY NAME	
_____ HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/>			
GROUP #	I.D.#	GROUP #	I.D.#
NAME OF INSURED (POLICY HOLDER)	DATE OF BIRTH	NAME OF INSURED (POLICY HOLDER)	DATE OF BIRTH
POLICY HOLDER ADDRESS		POLICY HOLDER ADDRESS	
PHONE #	SOCIAL SECURITY #	SEX	
PHONE #	SOCIAL SECURITY #	SEX	
POLICY HOLDER EMPLOYER		POLICY HOLDER EMPLOYER	
PATIENTS RELATIONSHIP TO INSURED	COPAY _____	PATIENT'S RELATIONSHIP TO INSURED	COPAY _____
<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> EMPLOYER		<input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> EMPLOYER	
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	OTHER _____	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	OTHER _____

<b>OFFICE USE ONLY</b>	CASE MGR _____	PHONE _____	FAX _____
	EMPLOYER <input type="checkbox"/> SEND BILLS <input type="checkbox"/> SEND NOTES	CARRIER <input type="checkbox"/> SEND BILLS <input type="checkbox"/> SEND NOTES	
	<input type="checkbox"/> IME _____	_____	
	<input type="checkbox"/> WC _____	_____	
	<input type="checkbox"/> AUTO _____	_____	
	<input type="checkbox"/> LIABILITY _____	_____	
CONTACT: _____	CLAIM #: _____		
PHONE: _____	ADJUSTER: _____		
CONF. BY _____	DATE: _____	PHONE: _____	