PATIENT INFORMATION FORM

Patient's Name	Date of Birth	Age	Social Security Number

Sex	Race	Marital Status
Male Female	White Black Hispanic Other	Single Married Widowed Divorced Separated

Address	City, State, & Zip Code	Home Phone Number
		( )

	Employer	Business Phone Number
		( )

Spouse's Name	Date of Birth	Social Security Number	Employer	Business Phone Number
				( )

Medical Physician	Major Complaint

RESPONSIBLE PARTY FOR MINOR OR STUDENT:

Father's Name	Address	Date of Birth	Home Phone Number
			( )
Father's Employer	**Social Security Number**		**Business Phone Number**
			( )
Mother's Name	**Address**	**Date of Birth**	**Home Phone Number**
			( )
Mother's Employer	**Social Security Number**		**Business Phone Number**
			( )

HOW DID YOU HEAR ABOUT US?

____ PHONEBOOK ____ FAMILY/FRIENDS

____ INTERNET ____ OTHER ____________________

IF YOU HAVE AN ATTORNEY INVOLVED IN THIS INJURY, PLEASE CHECK HERE: ________

AUTHORIZATION:

I hereby assign to my physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize my physician to furnish information to my insurance carrier concerning my illness and treatments.

SIGNATURE: ______________________________ DATE: ____________________

APPOINTMENT IS WITH:

DR. TAYLOR DR. REESOR DR. LITTLEJOHN DR. STANLEY DR. LANGFORD

Longview Orthopaedic Clinic Association
409 NORTH SIXTH STREET
LONGVIEW, TEXAS 75601
TELEPHONE (903) 758-2746
FAX (903) 758-7127

Today's Date: ______________________________

Patient's Name: ______________________________

Please fill out ALL of the following information below, if it does not apply then put N/A.

This injury was the result of an accident or injury: YES NO

Date of accident: ______________________________

Place of accident: ______________________________

Nature of accident: ______________________________
____
____
____

Was this work related: YES NO

Was this related to an automobile accident: YES NO

I hereby declare that the above information is complete and accurate to the best of my knowledge.

____
(Signature)

Longview Orthopaedic Clinic Association
409 NORTH SIXTH STREET
LONGVIEW, TEXAS 75601
TELEPHONE (903) 758-2746
FAX (903) 758-7127

MEDICAL RECORDS RELEASE FORM

I, ____________________________________, (DOB: ____________________) understand that the information contained in my medical record is confidential. However, I specifically give my consent for Longview Orthopaedic Clinic Association to release medical information to other doctors for further treatment in my care, hospitals, and/or insurance companies.

This consent may be revoked at any time up to the time that action is taken. It is further understood that the information released is for professional purposes only and should not be provided in whole or part to any other agency, organization, or person other than stated above.

I understand that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily give my consent for the release of information from my medical record.

____
SIGNATURE OF PATIENT
(OR PARENT, IF A MINOR)

____
Other names patient may be listed under
(i.e., maiden or other married names)

____
DATE

Longview Orthopaedic Clinic Association

Acknowledgement of Privacy Practices Form

I, ___________________________ acknowledge that I have read and understand the Notice of Privacy Practices as given to me this ________ day of _________________ 2007.

Printed Name: ______________________________

Signature: __________________________________

Social Security Number: ____________________

Witness: ___________________________________