

Cypress Creek Orthopedics & Sports Medicine
Richard A. Schram, M.D., PA

Date _____

Personal Information

> _____ **DOB:** _____
Last name First name MI

Sex: M F (circle one) Marital Status: S M D W (circle one)

> _____
Address City State Zip Code

> (____) _____ (____) _____
Home Phone Work Phone

> _____
Social Security Number Driver's License Number State

> _____
Employer (Parent's Info. if patient is a minor) Job Title Employer's Address

> _____ (____) _____ (____) _____
Emergency Contact/Parent or Guardian (if patient is a minor) Daytime Phone Number Evening/Cell Phone

> _____
Emergency Contact Relationship to patient

Insurance Information

> _____
Primary Insurance Carrier Address Phone Number

> _____
Policy Holder's Name DOB ID# Group #

> _____
Secondary Insurance Carrier Address Phone Number

> _____
Policy Holder's Name DOB ID# Group#

> _____
Person Responsible for Bill DOB SS# Relationship to Patient

> _____
Address Phone Number

Assignment of Benefits & Authorization

I hereby give authorization for payment of insurance benefits to be made directly to Cypress Creek Orthopedics for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature Date

