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PATIENT'S LAST NAME: _____ **FIRST NAME:** _____ **SEX:** _____

Date of Birth: ____/____/____ Address: _____

Social Security: ____ - ____ - ____ _____

CONTACT INFORMATION AND PERMISSIONS:

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Mobile Phone: (____) ____ - ____ Email Address: _____

How may we contact you with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Where may we leave a message with confidential medical information? (Circle all that apply)

HOME PHONE / WORK PHONE / MOBILE PHONE / EMAIL

Who else may we speak to regarding confidential medical information?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MARITAL STATUS: (circle one) Married / Single / Divorced / Separated / Widowed / Partner

INJURY INFORMATION: Car Accident: YES / NO On the Job Injury: YES / NO

OTHER CONTACTS:

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) ____ - ____

Financial Guarantor: (Write 'Self' if applicable)

Name: _____

Date of Birth: ____/____/____ Address: _____

Social Security: ____ - ____ - ____ _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID# _____ Group #: _____

Policy Holder's Name: _____ DOB: ____/____/____ SS# ____ - ____ - ____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify: _____)

Secondary Insurance: _____ ID#: _____ Group #: _____

Policy Holder's Name: _____ DOB: ____/____/____ SS# ____ - ____ - ____

Policy Holder's Relationship to Patient: SPOUSE / PARENT / SELF / OTHER (Specify: _____)

PREFERRED PHARMACY:

Pharmacy Name: _____ **Address:** _____ **Phone:** _____

Payment is required at the time services are rendered We wish to notify you that Dr. Mehta has ownership/interest in Preferred Imaging of Plano, Precision Surgery Center of Dallas, Reliant Rehabilitation Hospital of Richardson and shares in the profits in part from payments made by patients who maybe referred to these facilities. You are under no obligation to use these facilities.

I authorize payment of medical benefits by my insurance policy to Comprehensive Orthopaedics & Rehabilitation, P.A. I understand that I am responsible for the balance on the account regardless of my insurance policy. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as original. I hereby authorize said assignee to release all information necessary to secure payment. I authorize Comprehensive Orthopaedics & Rehabilitation, P.A. and its affiliated healthcare providers to treat me.

Patient Signature: X _____ **DATE:** _____