Jaafar M. Bazih, M.D.
Kevin M. Dukes, M.D.
Norman L. Dunitz, M.D.
Scott J. Dunitz, M.D.
James L. Griffin, M.D.
Ronald Hood, M.D.
A.I. (Tony) Jabbour, M.D.
John F. Josephson, M.D.
Thomas A. Marberry, M.D.

TULSA BONE & JOINT ASSOCIATES

4802 South 109th East Ave.
Tulsa, OK 74146

Brent C. Nossaman, D.O.
Terrill H. Simmons, M.D.
James C. Slater, M.D.
Richard M. Stamile, M.D.
Keith L. Stanley, M.D.
Wesley M. Stotler, D.O.
Richard D. Thomas, M.D.

PATIENT # _____ **PLEASE PRINT** DOCTOR # _____

Date _____

Patient Name _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone / ext. _____ Cell # _____ Spouse Work #: _____

Sex: ❑ Male ❑ Female Age ____ Birthdate ____ /_____ /_____ Marital Status: S M D W

SS# _____ Primary Care Physician _____
First Last

Referred by whom _____ Primary Care Physician _____
Address Phone #

Is patient in a nursing facility? ❑ Yes ❑ No If yes, address: _____

In case of emergency, Contact: _____ Phone (_____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE or WORKERS COMP CARRIER

Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Subscriber _____

Birthdate _____ /_____ /_____ SS# _____

Subscriber Relationship to Patient _____

Subscriber's Employer _____

Cert. No. _____ Group No. _____

Co-Pay (If Applicable) _____ Deductible _____

SECONDARY INSURANCE

Insurance Co. _____

Address _____

City _____ State _____ Zip _____

Subscriber _____

Birthdate _____ /_____ /_____ SS# _____

Subscriber Relationship to Patient _____

Subscriber's Employer _____

Cert. No. _____ Group No. _____

Co-Pay (If Applicable) _____ Deductible _____

Medicare patient working? ❑ Yes ❑ No Spouse working? ❑ Yes ❑ No

Patient's/Spouses Employer _____

Address _____ City _____ State _____ Zip _____

INJURY INFORMATION

Injury Details: _____

Date of injury _____ /_____ /_____ Area of Pain _____

INJURY? Yes / No Auto / Work / Other Were X-Rays taken? _____

How did injury occur? _____

Where did injury happen? _____

We will be notifying your health Insurance. Do you have an attorney ❑ Yes ❑ No Name _____

IF PATIENT IS A MINOR

Father's Name _____ Employer _____

Work Phone (_____) _____ Social Security No. _____

Mother's Name _____ Employer _____

Work Phone (_____) _____ Social Security No. _____

EACH PATIENT (OR RESPONSIBLE PARTY) IS FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. WHILE WE ARE PLEASED TO ASSIST IN THE PREPARATION OF INSURANCE FORMS, THE OBLIGATION FOR PAYMENT OF OUR FEES REMAINS THAT OF THE PATIENT.

I hereby authorize payment to Tulsa Bone & Joint Associates for medical services rendered. Including third party insurance carriers wherein the injuries suffered by me or my dependent resulted from the negligence or other acts or acts of others. I authorize the release of any information required in the course of my examination or treatment.

Signature _____ Date _____