

## PATIENT INFORMATION



**Sports Occupational & Knee Surgery, P.A.**

**PETER F. HOLMES, M.D.**  
Kathren Mccarty DPM

REFERRED BY (NAME)

ADDRESS

Payment is expected at the time services are rendered unless prior arrangements have been made.  
How are you going to pay for today's charges? Cash Check

### PATIENT INFORMATION

NAME (LAST)		FIRST		MIDDLE INITIAL)		ADDRESS			
CITY			STATE	ZIP	HOME PHONE (A/C & NO.)		CELL (A/C & NO.)		OTHER (A/C & NO.)
DATE OF BIRTH		MARITAL STATUS			SEX		SOCIAL SECURITY NUMBER		TDL #
		<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
OCCUPATION					EMPLOYER				
ADDRESS OF EMPLOYER								BUS. PHONE (A/C & NO.)	

### SPOUSE OR PARENT INFORMATION

NAME (LAST)		FIRST		MIDDLE INITIAL)		RELATIONSHIP	ADDRESS		PHONE (A/C & NO.)
EMPLOYER & ADDRESS						BUS. PHONE (A/C & NO.)		SOCIAL SECURITY NUMBER	
NEAREST RELATIVE (NOT LIVING WITH PATIENT)				RELATIONSHIP		ADDRESS		PHONE (A/C & NO.)	

### PERSON RESPONSIBLE FOR PAYMENT

NAME (LAST)		FIRST		MIDDLE INITIAL)		RELATIONSHIP TO PATIENT	IF WORKER'S COMP., NAME		
ADDRESS (IF DIFFERENT FROM ABOVE)								PHONE (IF DIFFERENT FROM ABOVE)	
DATE OF INJURY OR ONSET		ACCIDENT			ADJUSTER		PHONE (A/C & NO.)		
WORKER'S COMP. CLAIM NO.					TWCC #				

### INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE				ADDRESS OF PRIMARY INSURANCE COMPANY						
INSURED'S NAME			D.O.B.		S.S. #		GROUP NO.		ID NO.	
SECONDARY INSURANCE COVERAGE				ADDRESS OF SECONDARY INSURANCE COMPANY						
INSURED'S NAME			D.O.B.		S.S. #		GROUP NO.		ID NO.	
CO PAY	HMO	PPO	MEDICARE NUMBER				MEDICAID NUMBER			

**ASSIGNMENT OF BENEFITS**

I hereby assign payment of medical insurance benefits to the physician or physicians that rendered treatment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_, 20\_\_

**RELEASE OF MEDICAL INFORMATION**

I consent to the release of any medical information TO MY INSURANCE COMPANIES.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_, 20\_\_

9150 Huebner Road, Suite 200 • San Antonio, Texas 78240-1501 • Telephone (210) 696-9000 • Fax (210) 696-9012  
Satellite Office: 6051 FM 3009 • Schertz TX 78154-3236