Texas Health Physicians Group
Orthopedic Specialty Associates

Patient Name _____ Preferred Name _____ **DOB** _____

Marital Status ☐Single ☐Married ☐Other Spouse / Partner's Name _____

Employed ☐Yes ☐No **Occupation(s)** _____

Employer(s) _____ City/State _____

Student ☐Yes ☐No **School** _____ City/State _____

List all sports played _____ **Date of Injury** _____

Coach Name _____ Cell Phone # (_____)_____-_____

Athletic Trainer Name _____ Cell Phone # (_____)_____-_____

Athletic Trainer email _____

Who referred you to this office? ☐Physician ☐Coach ☐Trainer ☐Friend **Name** _____

Primary Care Physician _____ Cell Phone # (_____)_____-_____

Pharmacy _____ Cell Phone # (_____)_____-_____

If a minor, please provide parent/guardian information

Primary Contact

Name _____ Relation _____ Cell Phone # (_____)_____-_____

Secondary Contact

Name _____ Relation _____ Cell Phone # (_____)_____-_____

Name _____ Relation _____ Cell Phone # (_____)_____-_____

Release of Medical Information to School or Organization Medical and Operational Personnel:

I _____ (**Parent / Legal Guardian if above named patient is a minor**):

AUTHORIZE _____ **(Initials**) the release of all medical records from **Orthopedic Specialty Associates, Texas Health Physicians Group** to the above-mentioned school / organization and or school / organization representatives as it relates to my medical care (or to my child's medical care). This includes, but is not limited to: appointments, records, office dictations, treatment plans, test results, therapy reports and insurance information. **And I AUTHORIZE** the office personnel and medical providers at **Orthopedic Specially Associates, Texas Health Physicians Group** to personally discuss or disclose relevant information to the above-mentioned school / organization and or school / organization representatives as it relates to my (or my child's) appointments, treatment, medical care, test results, progress, prognosis, and insurance. This Authorization will remain in effect until I provide written Notification to **Orthopedic Specialty Associates, Texas Health Physicians Group** of changes or updates to this authorization.

DECLINE _____ **(Initials)** all communication and release of medical information to the above-mentioned school or organization and its representatives as it relates to my (or to my child's) medical care.

_____ _____

Signature (Self or Parent / Legal Guardian) **Date**