

Tulsa
Bone&Joint
Associates

William L. Surbeck, M.D

1919 S. Wheeling Ave. # 606
Tulsa, Ok 74104
Phone 918-748-7540

Alan L. Martin, M.D.

Patient # _____ *PLEASE PRINT* Doctor # _____
Date: _____ *Fill out all information to the best of your knowledge*
Patient Name: _____
Last First Middle
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone/ext: _____ Cell: _____
Sex: Male Female Age: _____ Birthdate: ___/___/___ Marital Status: S M D W
SS#: _____ Referred by whom: _____
Primary Care Physician: _____
First Last Address Phone
Employer: _____
In case of Emergency, Contact: _____ Phone:()

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. _____
Address _____
City _____ State _____ Zip _____
Subscriber Name _____
Birthdate ___/___/___ SS# _____
Subscriber Relationship to Patient _____
Subscriber's Employer _____
ID. No. _____ Group No. _____
Co-Pay (if Applicable) _____
Medicare patient working? Yes No

SECONDARY INSURANCE

Insurance Co. _____
Address _____
City _____ State _____ Zip _____
Subscriber Name _____
Birthdate ___/___/___ SS# _____
Subscriber Relationship to Patient _____
Subscriber's Employer _____
ID. No. _____ Group No. _____
Co-Pay (if Applicable) _____

IF PATIENT IS A MINOR

Father's Name _____
Work Phone (_____) _____
Mother's Name: _____
Work Phone(_____) _____

Employer _____
Social Security No. _____
Employer _____
Social Security No. _____

EACH PATIENT (OR RESPONSIBLE PARTY) IS FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. WHILE WE ARE PLEASE 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 my dependent or me resulted from the negligence or other acted or acts of others. I authorize the release of any information required in the course of my examination or treatment.

Signature _____

Date _____