BONE AND JOINT SURGERY ASSOCIATES, P.A.

Farbod Malek, M.D.

Tel. 210.865.9200
Fax 210.641.2805

PATIENT INFORMATION

Patient Name: ______________________________
Date of Birth: ____________ **Age**: ________ **SSN**: ____________
Address: ______________________________
City: ____________ **State**: ____________ **Zip**: ____________
Home Phone: ____________ **Cell Phone**: ____________ **Work**: ____________
Email: ______________________________
Employer: ______________________________
Preferred Language: ______________________________
Ethnicity (Circle one): Hispanic/Latino Non-Hispanic Other
Race (Circle one): American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Other Race
Marital Status (Circle one): Single Married Divorced Widowed

How were you referred to our office? ____________ **Phone:** ____________

PRIMARY INSURANCE

Insured's Name: ____________ **SSN:** ____________ **DOB:** ____________
Insurance Company: ____________ **ID#**: ____________ **Group#**: ____________

SECONDARY INSURANCE

Insured's Name: ____________ **SSN:** ____________ **DOB:** ____________
Insurance Company: ____________ **ID#**: ____________ **Group#**: ____________

PHARMACY INFORMATION

Pharmacy Name: ____________ **Phone**: ____________
Address: ____________ **Fax**: ____________

EMERGENCY CONTACT

Name: ____________ **Relationship**: ____________
Home Phone: ____________ **Cell Phone**: ____________ **Work**: ____________

Advanced Directives: (Circle all that apply)

DNR Living Will Medical Power of Attorney Organ Donor Special Instructions

FOR MINORS ONLY

Responsible Party Name: ____________ **Relation:** ____________
Date of Birth: ____________ **SSN:** ____________
Address: ______________________________