



Amarillo Bone & Joint Clinic, L.L.P.  
 Keith D. Bjork, M.D. J. Brian Sims, M.D.  
 Brad Veazey, M.D. Toby Risko, M.D.  
 Brian Haseloff, M.D.  
 3501 Soncy Rd., Suite 129 • Amarillo, TX 79119  
 Office: (806) 468-9700 Fax: (806) 468-9771

Date: \_\_\_\_\_

Age: \_\_\_\_\_ M / F

Patient Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Alternate phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address & Phone \_\_\_\_\_

Marital Status S M W D \_\_\_\_\_

**Responsible party/Insured**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address & Phone \_\_\_\_\_

**Emergency Contact, OTHER THAN SPOUSE (NOT IN SAME HOUSEHOLD)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Alternate Mailing Address \_\_\_\_\_

Phone \_\_\_\_\_ Alternate phone # \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address & Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company \_\_\_\_\_

Policy Holders Name / Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Policy Holders Name / Relationship \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

I authorize release of any medical or other information necessary to process this claim.

I understand that services rendered today are my financial responsibility. Insurance is filed as a courtesy to you, there may be a difference between your benefits and fees.

I assign payment of medical benefits to: Keith D. Bjork, MD (Amarillo Bone & Joint Clinic, PA), J. Brian Sims, MD, PA, Brad Veazey MD, PA, Toby Risko, MD, PA, or Brian Haseloff, MD, PA.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_