



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: _____