

Tarun Bhargava, M.D.

*MIS Anterior Hip Reconstruction,
Hip Resurfacing, Total and
Partial Knee Reconstruction*

Phillip F. Hagan, M.D.

*Arthroscopic Knee Surgery,
Shoulder Surgery and Sports Medicine*



**Orthopaedic
Sports Medicine
at Cypress**

Bradley W. Bruner, M.D.

*Arthroscopic Knee Surgery,
and Sports Medicine*

James Joseph Jr., M.D.

*Total Joint Reconstruction
of Knees and Hips*

9300 E. 29th St. N., Suite 205 | Wichita, KS 67226 | Tel: 316.219.8299 | 888.397.7362 | Fax: 316.219.5899

PATIENT INFORMATION

Doctor: _____ Date: _____ Time: _____ Patient ID#: _____

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Middle Initial)

Street Address: _____ SS# _____

City: _____ State: _____ Zip: _____ Male Female Single

Home Phone: _____ Work Phone: _____ Employed Unemployed Retired Married

Cell Phone: _____ E-mail: _____ Student Full Time Part Time Divorced

Employer: _____ Address _____ Widowed

REASON for this visit _____ Date of first Symptoms _____

If Injury give date _____ Home? JOB RELATED? Auto Accident? Sports? Other? _____

Where and how were you injured? _____

Have there been X-rays taken? Yes No Where? _____ When? _____ X-rays with you? Yes No

Is there an Attorney involved? Yes No If Yes, Attorney's Name and Phone number: _____

Referring Physician: _____ Family Physician: _____ Send Letters Yes No

EMERGENCY CONTACTS

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE POLICY HOLDER INFORMATION

| | |
|---------------------------------|---------------------------------|
| PRIMARY COMPANY: _____ | SECONDARY COMPANY: _____ |
| Address: _____ | Address: _____ |
| City, State: _____ Zip: _____ | City, State: _____ Zip: _____ |
| ID #: _____ Group #: _____ | ID #: _____ Group #: _____ |
| Subscribers Name: _____ | Subscribers Name: _____ |
| Date of Birth: _____ SS#: _____ | Date of Birth: _____ SS#: _____ |
| Address: _____ | Address: _____ |
| City, State: _____ Zip: _____ | City, State: _____ Zip: _____ |
| Employer: _____ | Employer: _____ |

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Responsible Party: _____ Responsible Party Date of Birth: _____

Address: _____

Relation to patient: _____ SS#: _____ Home Phone: _____

Responsible Party Employer: _____ Work Phone: _____

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME.
I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE BENEFITS TO ORTHOPAEDIC AND SPORTS MEDICINE AT CYPRESS.
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature of Patient/Insured: _____ Date: _____

Insured Signature (If other than patient): _____ Date: _____