all american orthopedic
& SPORTS MEDICINE INSTITUTE

Name			DOB		
Address				Sex	M /
City / Zip Code			Marital Status		M / S /
Cell			SS No		
Email			DL No		
Race			Language		
Employer			Work No		
Occupation		School you attend			
Emergency Contact			Phone		
Relationship to PT		Height		Weight	
Primary Care Dr			Phone		
Pharmacy			Phone		
Referred By					

I, being of legal age (18 or older), understand that I am responsible for all accounts with All American Orthopedic including a rendering Physician that may provide services during my visit. I authorize the release of information to my insurance compa

_____ _____

Patient/ Parent/ Legal Guardian Signature **Date**

Physician Ownership Disclosure Form

During the course of your physician/ patient relationship with Drs Holt, Jaglowski, Higgs, Hinojosa, Muffoletto or th representatives at All American Orthopedic & Sports Medicine Institute, you may be referred to any of the followin **Alliance MRI - 17490 Hwy 3, Webster, TX 77598 * Houston Physicians Hospital - 333 N Texas Ave #1000, Webster, TX**

How did you hear about us? Friend/ Family _____ Physician Referral _____ Magazine _____ Commerical _____ Ra

Any of these facilities may be out of network with your healthcare provider. You have the right to choose alternate hea providers. You will not be treated any differently by your Physician, the Physician's staff, or the facility. A list of specific P ownership and Physicians immediate family members ownership is available upon request. This information is being pr to you to help you make an informed decision about your healthcare.

_____ _____ _____/_____/_____

Patient Name Signature Date

M. Shaun Holt, MD * Matthew Higgs, MD * Jeffrey Jaglowski, MD * Anthony Muffoletto, MD * Lauren Hinojosa, MD

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