

PATIENT REGISTRATION THE SPORTS MEDICINE CLINIC

NEW PATIENT
 UPDATE

PLEASE PRINT PATIENT'S NAME

Acct # _____

Last:	First:	MI:
Address:		
City:	State:	Zip:
Home Phone:		
Work Phone:		
Cell Phone:		
Employer or School:		
Occupation:		
Social Security #:		
Birthdate:		
Sex:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/> Widowed <input type="checkbox"/>
Other:		

Person Responsible for Bill:

Name:		
Address:		
City:	State:	Zip:
Home Phone:		
Work Phone:		
Cell Phone:		

EMERGENCY CONTACT: *Nearest friend or relative not living with you*

1) Name	
Phone	
2) Name	
Phone	

PRIMARY INSURANCE	
Insurance Company:	
Group #:	Local #:
Policy Holder's Name:	
Policy Holder's SS #:	
Policy Holder's Birthdate:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

PCP _____ Co-pay _____

Patient's Relationship to Insured
 Self Spouse Child Other _____

SECONDARY INSURANCE	
Insurance Company:	
Group #:	Local #:
Policy Holder's Name:	
Policy Holder's SS #:	
Policy Holder's Birthdate:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Patient's Relationship to Insured
 Self Spouse Child Other _____

If you are being seen because of an **AUTO ACCIDENT** or an **INJURY THAT OCCURRED AT WORK**, PLEASE complete the following:

WORK INJURY	
Date of Accident:	
Employer at the Time of injury:	
Insurance Co.:	
Claim #:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Date of Injury/Symptom: _____

Cause of Injury: _____

Have you been treated by a physician for this problem: Yes No

If yes, name(s) of physician: _____

How did you hear about our clinic? _____

CAR ACCIDENT	
Date of Accident:	
Employer at the Time of injury:	
Insurance Co.:	
Claim #:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Body part involved _____ Left Right

ASSIGNMENT AND RELEASE: I authorize my insurance company to pay directly to **The Sports Medicine Clinic** for my treatment. I also authorize the release of any medical information necessary to process these claims. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. The above information is complete and accurate to the best of my knowledge.

I ACKNOWLEDGE RECEIPT OF A NOTICE OF PRIVACY PRACTICES, DESCRIBING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED.

SIGNATURE: _____ DATE: _____