

SPORTS MEDICINE ASSOCIATES, PLC: PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Sex: M F Birth date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone No: _____ Marital Status S M D W

Patient's Employer: _____ Retired, Date: _____

Employer's Address: _____ Work Phone No: _____

City: _____ State: _____ Zip Code: _____

RESPONSIBLE PERSON INFORMATION:

* Check if same as above

Name: _____ Birth date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

* Person to Contact in Case of Emergency: _____ Phone No: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE HOLDER

Medicare No: _____ Social Security # _____

PRIMARY INSURANCE:

Subscriber: _____ Birth date: _____

SECONDARY INSURANCE:

Subscriber: _____ Birth date: _____

Sports Medicine Associates tries very hard to verify each patients insurance. However, because there are so many different types and plans of insurance, we cannot know each and every policy. Therefore, it is the patient or patient's guardian(s) responsibility to know their own policy.

I AUTHORIZE THE RELEASE OF MEDICAL AND OTHER INFORMATION TO MY INSURANCE COMPANY FOR REVIEW OF MY COVERAGE AND/OR THE PROCESSING OF CLAIMS FOR SERVICES RENDERED TO ME. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY CHARGES INCURRED THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

Signature of Patient/Guardian: _____ Date: _____

Employee Verification Signature: _____ Date: _____