



Patient Information Record

Physician _____ Date _____ Chart _____
 Referred By _____
 Reason for Today's visit: _____

Last Name _____ First _____ Middle Initial & Suffix _____

Sex: Female Male Previous Last Name _____ Age _____ Date of Birth _____ Race _____

SSN _____ Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ General Physician _____

Patient Status (circle all that apply): Married Single Divorced Widow Homebound Retired Disabled Student

Type of Injury: Work Auto Sports Other _____ Injury Date _____ State of Injury _____
 (For injuries at Work, Please complete additional paperwork. We will not file Motor Vehicle Insurance)

How did you hear about us? General Physician ER Friend Website Another Patient Insurance
 (Please check all that apply) Directory School Contact Hospital LPGA Yellow Page Ads Other__

Guardian Last Name _____ First _____ Middle Initial & Suffix _____

Emergency Contact Name _____ Phone _____ Relationship _____

(Not living in same household)

Employer/School _____ Full Time Part Time Retired Student

Employer/School Address _____ Phone _____

Guarantor/Insured's Last Name: _____ First: _____ Middle Initial & Suffix: _____

Guarantor Address if Different from Patient: _____

Zip Code: _____ City: _____ State: _____

SSN _____ Date of Birth _____ Employer _____

Employer Address _____ Phone _____

Insurance Information-Primary Insurance Company Name: _____

Is this a group policy through your employer? YES or NO Group Number: _____

Insured's Name: _____ Date of Birth: _____ SSN: _____

Insurance ID Number/Contract Number: _____ Date: _____

Patient's relationship to insured: _____ Office visit co-pay \$: _____

Will you be paying co-pays and deductibles by: Cash Check Credit Card (MC, VISA, AMEX, DISC)

Insurance Information-Secondary Insurance Company Name: _____

Is this a group policy through your employer? YES or NO Group Number: _____

Insured's Name: _____ Date of Birth: _____ SSN: _____

Insurance ID Number/Contract Number: _____ Date: _____

Patient's relationship to insured: _____ Office visit co-pay \$: _____

Will you be paying co-pays and deductibles by: Cash Check Credit Card (MC, VISA, AMEX, DISC)

I have been shown a copy of Sports Medicine South, LLC (SMS) Privacy Notice and have been provided with a Patient Consent Form for treatment. The financial credit policy of SMS has been provided to me and I agree to the terms as stated in that policy. I hereby assign to SMS all benefits payable under the terms of my insurance policy listed above. I realize that I am responsible for any balance not payable by my insurance company. I also understand that I will be responsible for any expenses incurred in the collection of outstanding balances that I may have, whether it be from a collection agency or an attorney.

Signature of Patient/Guardian _____ Date _____