Patient Information Record

Name: ________________________________ ___________________________ _______ **Gender:** M F
Last First MI Circle One

DOB: ___/____/_______ **Previous Last Name:** ____________________ **SSN:**_____-______-_______

Address: ______________________________________ **City:** _________________ **State:**____ **Zip Code:** ________

Home Phone: ( ) ______-__________ **Work:** ( ) _______-_________ **Cell:** ( ) _______-_________

E-Mail Address: ________________________________ **How did you hear about us?:**______________________________

Race: ______________ **Marital Status (circle one):** Single Married Divorced Widowed

General Physician: _________________________________ **Pharmacy Name & Phone #:** ____________________________

Patient Status (circle if applicable): *Homebound* *Retired* *Disabled* *Student*

Employer/School:______________________________________ *Full Time* *Part Time* *Retired* *Student*

Employer Address:____ **Phone:** ( ) _______-__________

Type of Injury: Work Auto Sports Other:_________________ **Injury Date:** _______________

Emergency Contact: ___________________________ **Phone:**______________________ **Relationship**:________________

Guardian Name: _______________________________ _______________________ ____
Last First MI

A Current Insurance Card Must Be Presented to the Receptionist When Submitting Your Form

Primary Insurance Name: _________________________________ Group Number: ___________________

Insurance Issued Through (circle one): Employer Private Spouse Parent

Policy Holders Name: __________________________________ DOB: ___/____/_______ SSN:_____-______-_______

Insured's ID Number: _______________________________

Secondary Insurance Name: ________________________________ Group Number: ___________________

Insurance Issued Through (circle one): Employer Private Spouse Parent

Policy Holders Name: __________________________________ DOB: ___/____/_______ SSN:_____-______-_______

Insured's ID Number: ______________________________

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 th terms as stated in the 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 expenses incurred in the collection of outstanding balances that I may have, whether it be from a collections agency or an attorney. Payment is due at the time of service.

Signature of Patient /Guardian ____ Date _______________

OFFICE USE ONLY: Patient Number _____________ Old Chart Number _____________