Patient Information/Demographic Form

Patient Information
Patient Name:_____
Date of Birth:_____
Street:_____
City/State:_____
Zip Code:_____
Date of Injury:_____
Ailment:_____
MRI/XRAY Taken?_____

Contact Information
Primary H/C/W:_____
Secondary H/C/W:_____
Alternate:_____
Email:_____

Emergency Contact/ Guarantor Information:
Name:_____
Relation:_____
Phone:_____
Alt. Phone:_____

Referral Information:
Referring Physician:_____
Physician #:_____
Referred by a friend? Y/N
Name:_____
Phone:_____

Insurance Information
Primary:_____
Member ID:_____
Group #:_____
Phone:_____
Insured Name:_____
Insured DOB:_____
Relationship to Patient:_____

Secondary:_____
Member ID:_____
Group #:_____
Phone:_____
Insured Name:_____
Insured DOB:_____
Relationship to Patient:_____

AUTHORIZTION I authorize The Orthopedic Sports Clinic to secure medical information from other providers, and to release medical information to insurers (including Medicare if appropriate) and other physicians. I authorize The Orthopedic Sports Clinic to release medical and insurance information to outside agents used to assist diagnosis and treatment. I understand these may be faxed. I further authorize the physicians treating me to perform basic office procedures such as manipulations, casting, taking x-rays, and performing injections as they are discussed with me. I authorize the use of my verbal consent in lieu of a written consent for these procedures, which have been explained to me. I also authorize benefits to be paid directly to The Orthopedic Sports Clinic on my behalf. I understand I am financially responsible for any balance not covered by my insurance. A copy of this signature is as valid as the original. I also understand that it is my responsibility to make sure that my referral is accurate, and denial of payment because of my not obtaining this will result in my being personally responsible for the charges incurred. I also understand that it is my responsibility to make sure that all insurance information provided is accurate and up to date. If it is not, I will assume responsibility for charges that are denied because of not filing to the right carrier in a timely fashion.

_____ _____
Signature Date