PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ Middle Initial: _____

If minor, Parent's Name: _____

Date of Birth: _____ *SSN:* _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

SSN: _____ Driver's License Number & State _____

Home Telephone #: _____ Cell phone #: _____

Work Telephone #: _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: White Black or African American Asian American Indian or Alaska Native

Native Hawaiian or other Pacific Islander Other Race

Preferred Language: English Other, please specify _____

Primary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Secondary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Family Physician Name & Telephone #: _____

Emergency Contact's Name: _____ Telephone #: _____

How were you referred to our office? _____

Is this a result of a Motor Vehicle Accident? _____ Work Injury? _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY FOR SEVICES RENDERED TO BE SENT DIRECTLY TO ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY, AND/OR MY PERSONAL ATTORNEY, _____ CONCERNING MY TREATMENT, AND THE RELEASE OF MY MEDICAL RECORDS TO ANY PHYSICIAN OR FACILITY TO WHOM I AM REFERRED.

PLEASE NOTE:
ALL CHARGES ARE PAYABLE AT THE TIME OF SERVICE. CHARGES FOR PROFESSIONAL SERVICES ARE THE RESPONSIBILITY OF THE PATIENT REGARDLESS OF INSURANCE COVERAGE.

AN ADMINISTRATIVE FEE OF $20.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

SIGNATURE: _____ DATE: _____