



**Orthopedics and Sports Medicine, P.A.**

**PATIENT INFORMATION SHEET**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**NAME OF PARENT/LEGAL GUARDIAN**  
**(IF PATIENT IS A MINOR)** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

**HOME PHONE** \_\_\_\_\_ **CELL PHONE** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **AGE** \_\_\_\_\_ **MARITAL STATUS** \_\_\_\_\_

**EMAIL ADDRESS** \_\_\_\_\_ **OK TO CONTACT VIA EMAIL ?** Y N

**EMERGENCY CONTACT** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**REFERRING PHYSICIAN** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**PATIENT'S EMPLOYER** \_\_\_\_\_

**CITY** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_

**ARE YOU A STUDENT?** \_\_\_\_\_

**PRIMARY INSURANCE** \_\_\_\_\_

**I.D. NUMBER** \_\_\_\_\_ **Group #** \_\_\_\_\_

**POLICY HOLDER** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **RELATION** \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

**I.D. NUMBER** \_\_\_\_\_ **Group #** \_\_\_\_\_

**POLICY HOLDER** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **RELATION** \_\_\_\_\_

**PHARMACY INFORMATION (ALL RX'S ARE ELECTRONICALLY SENT TO YOUR PHARMACY)**

**NAME:** \_\_\_\_\_

**STREET ADDRESS:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**PLEASE COMPLETE MEDICAL INFORMATION ON REVERSE SIDE**

