



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 _____

EMAIL ADDRESS _____ OK TO CONTACT VIA EMAIL ? Y N

EMERGENCY CONTACT _____ PHONE _____

DATE OF BIRTH _____ AGE _____ SOC SEC # _____

MARITAL STATUS _____ SPOUSE _____ DATE OF BIRTH _____

REFERRING PHYSICIAN _____ PHONE _____

NAME OF EMPLOYER _____

CITY _____ WORK PHONE _____

PRIMARY INSURANCE _____

I.D. NUMBER _____ Group # _____

POLICY HOLDER _____ DATE OF BIRTH _____ RELATION _____

SECONDARY INSURANCE _____

POLICY HOLDER: _____ I.D. NUMBER _____

I AUTHORIZE ACTIVE ORTHOPAEDICS AND SPORTS MEDICINE, PA TO FURNISH ANY RECORDS OF MEDICAL HISTORY FOR SERVICES RENDERED OR TREATMENT GIVEN TO ME FOR THE PURPOSE OF REVIEW OR FILING A CLAIM WITH MY INSURANCE CARRIER. IF APPLICABLE, I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS OR ANY PORTION OF THE BILL THAT MY INSURANCE COMPANY DOES NOT APPROVE/DENY. I UNDERSTAND THAT IF REQUIRED, A VALID REFERRAL IS DUE AT THE TIME OF SERVICE ,OTHERWISE MY APPOINTMENT WILL BE RESCHEDULED.

Signature of Patient or Responsible Party _____

Date _____

PLEASE COMPLETE MEDICAL INFORMATION ON REVERSE SIDE