



For office use only: Account # _____

Physician: _____

Date: _____

WELCOME TO PREMIER ORTHOPAEDICS & SPORTS MEDICINE, PLC

PATIENT'S INFORMATION

Patient's Full Name: (First) _____ (Middle) _____ (Last) _____

Home Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: (_____) _____ Social Security #: _____ - _____ - _____

Male Female Birth Date: _____ / _____ / _____ Age: _____

Marital Status: Single Married Divorced Widowed Spouse's Name: _____

Patient's Employer: _____ Work Phone: (_____) _____

Employer's Address: _____

Occupation: _____ Cell Phone: (_____) _____

BILLING INFORMATION

Please indicate the person responsible for the bill by checking one of following boxes:

Patient. *If the patient is 18 years old or older and is the responsible party, please skip this section.*

Someone other than the patient is the responsible party and/or is the insured, such as a spouse or a legal guardian accompanying a minor child.

If the insurance subscriber (policy holder) is not the patient, please complete the following information:

Name of Insurance Company: _____

Name of Subscriber: _____ Relationship to Patient: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

REFERRAL INFORMATION

Who referred you? Family or Friends Doctor _____ If other, specify: _____

Who is your family physician? _____

REASON FOR VISIT INFORMATION

Is this due to an injury? Yes No If yes, what was the date of the injury: _____ / _____ / _____

If yes, check one: Auto Accident On the Job Injury If other, specify: _____

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Premier Orthopaedics & Sports Medicine, PLC.

Signature of Patient or Responsible Party

Today's Date