



WELCOME TO PREMIER ORTHOPAEDICS & SPORTS MEDICINE, PLC

For office use only: Account # Physician: Date:

PATIENT INFORMATION

Full Name: (First) (Middle) (Last)
Home Address:
Zip Code: City: State:
Home Phone () SS # - - M F Birth Date: / / Age:
Marital Status: Single Married Divorced Widowed Spouse's Name:
Patient's Employer: Work Phone: ()
Employer's Address:
Occupation: Cell Phone: ()

RESPONSIBLE PARTY (BILL TO) INFORMATION

--- Complete this section ONLY if someone other than the patient is financially responsible. ---

Responsible Party: (First) (Middle) (Last) M F
Address:
Zip Code: City: State:
Home Phone: () Work Phone: () Cell Phone: ()
Social Security #: - - Relationship to Patient: Birth Date: / /
Name of Employer:

EMERGENCY CONTACT INFORMATION

Name: Relationship:
Home Phone: () Work Phone: () Cell Phone: ()

REFERRAL INFORMATION

Who referred you to our office? Who is your Family Physician?

INSURANCE INFORMATION

Primary Insurance Co: Group #: Policy #:
Name of Insured: SS # - - Birth Date / / Relationship to Patient:
Secondary Insurance Co: Group #: Policy #:
Name of Insured: SS # - - Birth Date / / Relationship to Patient:
If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral? Yes No

REASON FOR VISIT AND RELATED INFORMATION

Problem to be treated on today's date: Right Left
Is this due to an accident or injury? Yes No If yes, date of accident or injury: / /
If yes, please check one of the following: Auto Accident Liability On the Job Injury Other (home, etc.)
Is an attorney involved? Yes No If on the job, did you report this injury to your employer? Yes No
Was the patient seen in the Emergency Room? Yes No Date: Hospital:
Has the patient had any of the following related to this visit? X-Rays Yes No MRI Yes No CT Yes No EMG Yes No
Where were these films/studies done? (facility) Did you bring the films with you? Yes No

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