For office use only: *Account #* *Physician:* *Date:*

WELCOME TO PREMIER ORTHOPAEDICS & SPORTS MEDICINE, PLC

➔ **Patient's Full Name:** *(First)* ____________ *(Middle)* ____________ *(Last)* ____________

REASON FOR VISIT AND RELATED INFORMATION

Problem to be treated today: ❑ Right Side ❑ Left Side

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:

Is an attorney involved? ❑ Yes ❑No If hurt 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 SCAN** ❑Yes ❑No **EMG** ❑Yes ❑No

Where were these films/studies done? (facility) Did you bring the films with you? ❑ Yes ❑ No

PATIENT'S INFORMATION

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: ( ) Other Phone or Pager: ( )

🡻 **PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE** 🡻

RESPONSIBLE PARTY *(BILL TO)* INFORMATION

➔ **If PATIENT is 18 years old or older and is the responsible party, skip this section and go to the EMERGENCY CONTACT section.**

➔ **If someone other than the patient is the responsible party, complete the following information:**

Name: *(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: Employer Phone: ( )

EMERGENCY CONTACT INFORMATION

1.) Name: Relationship:

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

2.) 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?

INSURANCE INFORMATION

➔ **If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral? ❑ Yes ❑ No**

1.) Primary Insurance Company:

Group or Account #: ID or Policy #:

Name of Insured: Social Security #: - -

Birth Date: / / Relationship to Patient:

2.) Secondary Insurance Company:

Group or Account #: ID or Policy #:

Name of Insured: Social Security #: - -

Birth Date: / / Relationship to Patient:

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*