



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: (_____) _____

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