SOUTHWEST SPORTS MEDICINE AND ORTHOPEDIC SURGERY CLINIC

PATIENT INFORMATION

Patient
Name:_____DOB_____
Last First MI

Address:_____City_____State:_____Zip:_____
Home Phone:_____Cell:_____Email:_____

Employer:_____Occupation:_____
Phone:_____

Primary Care Physician:_____

Emergency Contact:_____Phone:_____Relation to patient: _____

INSURANCE INFORMATION

Primary Insurance
Carrier:_____ID:_____Group:_____
Claims
Address_____City_____State_____Zip_____

Insurance Phone:_____Eff.Date:_____Insured:_____DOB:_____

Relationship to patient:_____Employer:_____

Secondary Insurance
Carrier:_____ID:_____Group:_____
Claims
Address_____City_____State_____Zip_____

Insurance Phone:_____Eff.Date:_____Insured:_____DOB:_____

Relationship to patient:_____Employer:_____

If this is an industrial accident, please provide the following:

Industrial insurance_____ Claim#:_____Adjuster:_____
Adjuster Phone:_____ Date of Injury:_____

Authorization for Assignment of Benefits / Information Release: I, the undersigned, authorize payment of medical benefits to Southwest Sports Medicine for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will only be used for evaluating and benefits purposes. In the event of default, I promise to pay collection costs and reasonable fees as may be required to collect the unpaid balance on my account.

SIGNED (Patient or Parent if minor):_____Date:_____