Patient Information Sheet

Patient Last Name ________ Patient First Name ________ Middle Initial ____

Address ________ City ________ St ____ Zip ____

Soc. Sec. # ____________ Birth Date ____________ Home Phone ________ Cell Phone ________

Occupation ________ Employer ________ Work Phone ________

Marital Status ________ Spouse Name ________

Spouse's SS# ____________ Spouse's Birth Date ____________ Spouse Employer ________ Work Phone ________

DATE SYMPTOMS BEGAN (mm/dd/yy) ____________

How did this happen? ________

Part of the body being seen for ________ Right ❒ Left ❒

Primary Care Physician: ________

Did your injury happen on the job? ❒ Yes ❒ No

If yes, on what date? ________

Did you report to your employer? ❒ Yes ❒ No

Is this injury auto accident related? ❒ Yes ❒ No

Do you have an attorney? ❒ Yes ❒ No

Attorney Name: ________

Referred by (if other than Primary Care Physician): ________

Primary Insurance ________

Policyholder's Last Name ________ First Name ________ Middle Initial ____ ❒ Male ❒ Female

Birth Date ____________ ID # ________ Relationship to Patient ________

Home Phone: ________ Work Phone: ________ Ext. ____ Cell Phone: ________

Secondary Insurance ________

Policyholder's Last Name ________ First Name ________ Middle Initial ____ ❒ Male ❒ Female

Birth Date ____________ ID # ________ Relationship to Patient ________

Home Phone: ________ Work Phone: ________ Ext. ____ Cell Phone: ________

<u>If patient is a minor, parent or guardian please complete:</u>

Mother ________ Occupation ________ Employer ________

Home Phone ________ Business Phone: ________ Social Security # ____________

Father ________ Occupation ________ Employer ________

Home Phone ________ Business Phone: ________ Social Security # ____________

IN CASE OF EMERGENCY (Person **<u>NOT LIVING WITH</u>** patient):

Emergency Contact Last Name ________ First Name ________ Middle Initial ____

Relationship to patient ________ Daytime Phone ________

<u>Insurance Authorization and Assignment of Benefits</u>

I hereby authorize the physicians and physicians' assistants at Bahri Orthopedics and Sports Medicine to treat my illness or injury.

I authorize the release of any medical information necessary to process my claim, and I authorize payment of medical and surgical benefits to Bahri Orthopedics and Sports Medicine. If my insurance company denies payment, I will be responsible for the balance of the account. Co-payments are due at the time of service.

Signature ________________ Date ____________

(If a minor, the parent/legal guardian's signature is required.)

Rev. Date 02/07/08