

CENTER FOR JOINT SURGERY & SPORTS MEDICINE PATIENT INFORMATION

Patient Name _____	Birth Date _____	Soc. Sec. # _____
Mailing Address _____	City _____	State _____ Zip _____
Home Phone _____	Cell Phone _____	Sex M F
Marital Status S M D W	PCP/Family Doctor _____	

Employed? Full Time Part Time Retired Not Employed	Occupation _____
Employer _____	Phone Number _____

Spouse's Name _____	Birth Date _____	Soc. Sec. # _____
Spouse's Employer _____	Phone Number _____	

If Under 18-Parent/Guardian/Responsible Party _____	
Home Phone _____	Work Number _____
Mailing Address (If Different From Patient's) _____	

Emergency Contact _____	Phone Number _____	Relationship _____
Name(s) of family/friends we may discuss your treatment with _____		

Is This Visit A Result Of An Accident? Y N	Describe Injury _____
Date & Place Of Injury _____	Referring Doctor _____

Check Here If you DO NOT have Insurance <input type="checkbox"/> * PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO PHOTOCOPY	
Primary Insurance Company _____	Subscriber _____
Relationship _____	Birth Date _____ Employer _____
ID # _____	Group # _____ Do You Have A Co-Pay? Y N \$ _____
Secondary Insurance Company _____	Subscriber _____
Relationship _____	Birth Date _____ Employer _____
ID # _____	Group # _____ Do You Have A Co-Pay? Y N \$ _____

I hereby authorize Center for Joint Surgery and Sports Medicine to apply for benefits on my behalf and/or my dependants for services rendered. I request that payment by my insurance company/companies be made directly to Center for Joint Surgery and Sports Medicine.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical information for this or any related claim, to process my claims. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.

X _____
 Patient/Guardian/Responsible Party Relationship To Patient Date