

Center For Joint Surgery & Sports Medicine
Patient Information Form

Patient Name _____	Birth Date _____	Soc. Sec. # _____
Mailing Address _____	City _____	State _____ Zip _____
Home Phone _____	Cell Phone _____	Sex _____
Email _____		
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 _____		

Reason for Visit _____
Date of Onset _____

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 \$ _____

Can appointment reminders be left of your answering machine or voice mail? YES NO

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 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 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