SPORTS MEDICINE & ORTHOPEDIC CENTER **PHONE (414) 647-0033 / FAX (414) 647-0079**

TODAY'S DATE _____/_____/_____ SMOC PHYSICIAN _____ ACCOUNT # _____

PATIENT'S INFORMATION

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS _____ APT#_____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____ WORK PHONE (_____)_____ CELL PHONE (_____)_____

BIRTHDATE _____/_____/_____ MALE ( ) FEMALE ( ) SSN _____- _____- _____ MARITAL STATUS: MARRIED ( ) SINGLE ( ) OTHER_____

EMPLOYER _____ STUDENT: FULL-TIME ( ) PART-TIME ( )

SPOUSE NAME _____ SPOUSE PHONE (_____)_____ SPOUSE EMPLOYER _____

PRIMARY CARE PHYSICIAN _____ PRIMARY CARE PHYSICIAN PHONE # (_____)_____

REFERRED BY ( ) DOCTOR _____ **( ) OTHER** _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE (_____)_____

WAS THIS AN ACCIDENT OR INJURY? YES / NO **IF YES, IN WHAT STATE DID THE ACCIDENT OR INJURY TAKE PLACE?** _____

HOW DID ACCIDENT HAPPEN? WORK INJURY ( ) AUTO ACCIDENT ( ) OTHER ( ) EXPLAIN _____

DATE OF INJURY _____/_____/_____ **WHAT PART OF YOUR BODY WAS INJURED?** _____ IF EXTREMITY: RIGHT / LEFT / BOTH

IF THIS TREATMENT IS FOR A WORK-RELATED INJURY, YOU MUST COMPLETE THE FOLLOWING INFORMATION:

EMPLOYER AT THE TIME OF INJURY _____ EMPLOYER PHONE (_____)_____

EMPLOYER ADDRESS _____ CITY / STATE / ZIP _____

WORK COMP INSURANCE _____ ADDRESS _____

WORK COMP CLAIM #_____ ADJUSTER NAME _____ PHONE (_____)_____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____ INS. ADDRESS _____

ID # _____ GROUP # _____ INS. PHONE (_____)_____

SUBSCRIBER'S NAME _____ DOB _____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SUBSCRIBER'S ADDRESS IF DIFFERENT FROM ABOVE _____ PHONE (_____)_____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____ INS. ADDRESS _____

ID # _____ GROUP # _____ INS. PHONE (_____)_____

SUBSCRIBER'S NAME _____ DOB _____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SUBSCRIBER'S ADDRESS IF DIFFERENT FROM ABOVE _____ PHONE (_____)_____

I hereby authorize Sports Medicine & Orthopedic Center to release to the insurance company/companies listed on this form any information acquired in the course of my examination and/or treatment and to receive all payments for such examination and/or treatment. If you are covered by insurance, we will submit charges to the insurance company on your behalf. Co-pays are to be paid at the time the service is rendered. I understand that I am financially responsible for any portion not covered by the above insurance(s).

Signature of Patient _____ **Date** _____/_____/_____