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 _____

BIRTHDATE _____/_____/_____ AGE _____ MALE ( ) FEMALE ( ) SSN _____ - _____ - _____ FULL-TIME STUDENT ( ) PART-TIME STUDENT ( )

ADDRESS _____ APT#_____ CITY _____ STATE _____ ZIP _____

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

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

REFERRED BY ( ) DOCTOR _____ ( ) OTHER _____

IF PATIENT IS A MINOR: LIVES WITH: BOTH PARENTS ( ) MOTHER ( ) FATHER ( ) OTHER ( ) RELATIONSHIP TO CHILD_____

PARENTS' MARITAL STATUS: MARRIED ( ) SINGLE ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED ( ) PRIMARY CAREGIVER _____

MOTHER'S INFORMATION

FIRST & LAST NAME _____

DATE OF BIRTH _____/_____/_____ SSN _____ - _____ - _____

EMPLOYER _____

HOME PHONE (_____)_____

WORK PHONE (_____)_____

CELL PHONE (_____)_____

ADDRESS IF DIFFERENT FROM PATIENT _____

_____

FATHER'S INFORMATION

FIRST & LAST NAME _____

DATE OF BIRTH _____/_____/_____ SSN _____ - _____ - _____

EMPLOYER _____

HOME PHONE (_____)_____

WORK PHONE (_____)_____

CELL PHONE (_____)_____

ADDRESS IF DIFFERENT FROM PATIENT _____

_____

IS THIS THE RESULT OF AN ACCIDENT OR INJURY? NO ( ) YES ( ) DATE ____/____/____ DESCRIBE _____

PRIMARY INSURANCE INFORMATION

INS. COMPANY _____ INS. ADDRESS _____

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

SUBSCRIBERS NAME _____ DOB _____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

*ADDRESS IF DIFFERENT FROM ABOVE _____ PHONE (_____)_____

SECONDARY INSURANCE INFORMATION

INS. COMPANY _____ INS. ADDRESS _____

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

SUBSCRIBERS NAME _____ DOB _____/_____/_____ SSN# _____-_____-_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

*ADDRESS IF DIFFERENT FROM ABOVE _____ PHONE (_____)_____

I hereby authorize Sports Medicine and Orthopedic Center to evaluate and treat my above-named child and release to our insurance company any information acquired in the course of my child's examination and/or treatment, and to receive all payments for such exam/treatment. If the child is covered by insurance, we will suibmit charges to the insurance company on your henalf. Co-pays must be paid at the time the service is rendered. If payment of account balance cannot be made at the time of service, payment arrangements must be made. In divorce situations, the responsible parent is the parent bringing the child to the office visit regardless of divorce decree. Payment issues must be resolved between the parents. I understand that I am responsible for payment of services unpaid by the insurance company.

Signature of Parent/Guardian _____ Date _____/_____/_____