

Date: _____

PATIENT INFORMATION

Chart #: _____

All sections MUST be completed. If not applicable, please indicate as "N/A"

Have you ever been treated by one of our physicians? No Yes, by Dr. _____ Approximate Date _____
Was this injury sustained on the job? Yes No If so, has a claim been filed with your employer? Yes No

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____
Sex _____ Birthdate ____/____/____ Age _____ SS# _____ - _____ - _____ Marital Status: S M W D
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
Employer/School Name _____ Employed: Full Time Part Time Student: Full time Part time
Employer/School Address _____ City _____ State _____ Zip _____ Phone (____) _____ - _____
Driver's License #/State _____ Primary Care / Family Physician's Name _____

EMERGENCY CONTACT

1st Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____
2nd Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

REFERRED BY

Doctor Hospital/Clinic Patient Friend/Co-Worker Family Member HMO/PPO Directory
 Employer Referral Service Yellow Pages Print Advertising Internet Radio School Other _____
If referred by a physician: Last Name _____ First Name _____ Phone # _____
If referred by another source, list specific name (i.e hospital, school, or friend's name) _____

PRIMARY INSURANCE (complete blanks below with *insured's* information)

Insured's Name _____
Sex _____ Date of Birth _____ SS# _____
Patient's Relationship to Insured _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone # (____) _____ - _____
Claims Filing Address _____
City _____ State _____ Zip _____
ID# _____ Group # _____

SECONDARY INSURANCE (complete with *insured's* information)

Insured's Name _____
Sex _____ Date of Birth _____ SS# _____
Patient's Relationship to Insured _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone # (____) _____ - _____
Claims Filing Address _____
City _____ State _____ Zip _____
ID# _____ Group # _____

GUARANTOR (if other than patient)

Last Name _____ First Name _____ M.I. _____ Sex _____ Birthdate _____
SS#: _____ - _____ - _____ Driver's License # /State _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Austin Sports Medicine. **CONSENT FOR TREATMENT:** I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____