SportsMED Orthopedic Center

Date: _____ Account #: _____

How did you hear about SportsMED? _____

Referring Physician: _____ /Primary Care Physician: _____

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ DOB: _____ SSN: _____

Phone 1: _____ Phone 2: _____ Marital Status: _____ Sex: _____ Email: _____

Ethnicity: _____ Race: _____ Preferred Language: _____ ☐ Decline to answer

Employer: _____ Occupation: _____ Work Phone: _____

Insurance Information:

Primary Insurance: _____ I.D.#: _____ Group #: _____

Secondary Insurance: _____ I.D.#: _____ Group #: _____

Please complete if insured and patient are not the same for either primary or secondary insurance:

Name of Insured: _____ DOB: _____ SSN: _____

Address (including City, State, Zip): _____

Employer: _____ Relationship to Patient: _____

Responsible Party if Patient is a Minor:

Responsible Party: _____ Relationship to Patient: _____

Address (including City, State, Zip): _____

Emergency Contact:

Name: _____ Phone #: _____ Relationship to Patient: _____

Patient Condition Information:

Please explain reason for visit: _____

Job related injury? Yes ☐ No (if yes, please see front desk) Auto accident? Yes ☐ No ☐

If condition is an injury or accident, please provide date of injury and state in which it occurred: _____

Briefly explain how the injury occurred: _____

Were you seen in the hospital for this injury? Yes ☐ No ☐

Did you see a SportsMED physician in the hospital? Yes ☐ No ☐

Name of the hospital in which you were seen? _____

If no injury occurred, provide the date your pain began: _____