

## Patient Information Sheet

Patient Last Name _____		Patient First Name _____		Middle Initial _____	
Address _____		City _____		St _____ Zip _____	
Soc. Sec. # _____		Birth Date _____		Home Phone _____ Cell Phone _____	
Occupation _____		Employer _____		Work Phone _____	
Marital Status _____		Spouse Name _____			
Spouse's SS# _____		Spouse's Birth Date _____		Spouse Employer _____ Work Phone _____	

DATE SYMPTOMS BEGAN (mm/dd/yy) _____		Did your injury happen on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date? _____	
How did this happen? _____		Did you report to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this injury auto accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part of the body being seen for _____		Do you have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No Attorney Name: _____	
Right <input type="checkbox"/> Left <input type="checkbox"/>			
Primary Care Physician: _____			
Referred by (if other than Primary Care Physician): _____			

Primary Insurance _____			
Policyholder's Last Name _____		First Name _____ Middle Initial _____	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date _____		ID # _____ Relationship to Patient _____	
Home Phone: _____		Work Phone: _____ Ext. _____ Cell Phone: _____	

Secondary Insurance _____			
Policyholder's Last Name _____		First Name _____ Middle Initial _____	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date _____		ID # _____ Relationship to Patient _____	
Home Phone: _____		Work Phone: _____ Ext. _____ Cell Phone: _____	

**If patient is a minor, parent or guardian please complete:**

Mother _____		Occupation _____		Employer _____	
Home Phone _____		Business Phone: _____		Social Security # _____	
Father _____		Occupation _____		Employer _____	
Home Phone _____		Business Phone: _____		Social Security # _____	

<b>IN CASE OF EMERGENCY (Person <u>NOT LIVING WITH</u> patient):</b>			
Emergency Contact Last Name _____		First Name _____ Middle Initial _____	
Relationship to patient _____		Daytime Phone _____	

### Insurance Authorization and Assignment of Benefits

I hereby authorize the physicians and physicians' assistants at Bahri Orthopedics and Sports Medicine to treat my illness or injury.

I authorize the release of any medical information necessary to process my claim, and I authorize payment of medical and surgical benefits to Bahri Orthopedics and Sports Medicine. If my insurance company denies payment, I will be responsible for the balance of the account. Co-payments are due at the time of service.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If a minor, the parent/legal guardian's signature is required.)