Date: _____ File # _____

SPORTS MEDICINE CLINIC OF NORTH TEXAS

Please print, answer <u>all</u> questions and sign where indicated

Patient's Name: _____ Sex ☐ M ☐ F Marital Status: _____
First MI Last

SS# _____ DOB _____ Age _____

Home Address: _____
City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____ Fax: ( ) _____

Cell Phone: ( ) _____ E-Mail: _____

Employed ☐ Name of Employer _____ | Student ☐ Name of School _____

PARENTAL INFORMATION FOR MINORS (for patients under the age of 18)

Mother's Name: _____ Father's Name: _____

Mother's Date of Birth: _____ SS# _____ Father's Date of Birth: _____ SS# _____

PERSON RESPONSIBLE FOR PAYMENT

☐ Same as Patient If different, please complete below:

Name: _____ Relationship to Patient: _____

Address: _____
City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Social Security#: _____ Date of Birth: _____

PRIMARY INSURANCE

Please check if this injury is to be filed under Workmen's Compensation? ☐

Insured: ☐ Same as Patient If different, Insured's Name: _____

↓ Insured's Date of Birth: _____ SS#: _____

Name of Insurance Company _____

ID Number: _____ Group No.: _____

SECONDARY INSURANCE

Insured: ☐ Same as Patient If different, Insured's Name: _____

↓ Insured's Date of Birth: _____ SS#: _____

Name of Insurance Company _____

ID Number: _____ Group No.: _____

FAMILY PHYSICIAN

Name: _____ Phone No.: _____

Address: _____

Currently under treatment: ☐ Yes ☐ No If yes, for what: _____

Were you referred by another physician? ☐ Yes ☐ No Name: _____

Address: _____ Phone No.: _____

Have you seen this physician for current injury? ☐ Yes ☐ No If yes, date of last visit: _____

Were you referred by someone else? ☐ Yes ☐ No Who: _____

EMERGENCY CONTACT – Name of relative or friend not living at your address to contact in case of an emergency:

Name: _____ Phone No.: _____

AUTHORIZATION TO TREAT:

I, the undersigned, hereby give my permission to receive evaluation and/or consultation and/or treatment or any other professional services rendered by Sports Medicine Clinic of North Texas to any employees or agents.

_____

Patient/Guardian Signature Date