



Patient Registration Form Account#: _____ Physician: _____

PLEASE PRINT

Patient Information

Patient Name: _____
 Address: _____
 City, State, Zip: _____ E-Mail Address: _____
 Home Phone : _____ Work Phone: _____ Cell: _____
 Birth Date: _____ Age: _____ Sex: Male Female
 Occupation: _____ Patients Social Security#: _____
 Employer Address: _____
 Spouse or Nearest Relative (Name/Phone/Address) : _____
 Primary Care Physician: _____
 Date of Injury: _____ Mechanism of Injury: _____
 Was your injury sustained at work? Yes No If Yes, has claim been filed Yes No
 How Did You Hear Of This Practice: _____

Responsible Party Information

Responsible Party: _____ Relationship to Patient: _____
 Home Phone: _____ Work Phone: _____ Cell: _____
 Occupation: _____ Patients Social Security#: _____
 Employer Address: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
 Insurance Co Name : _____ Insurance Co Name: _____
 Policy Holder: _____ Policy Holder: _____
 Policy Holders SS#: _____ Policy Holders SS#: _____
 Policy Holders DOB: _____ Policy Holder DOB: _____
 Relationship to Patient: _____ Relationship to Patient: _____

Workman's Compensation Insurance

Insurance Carrier: _____ Claim #: _____
 Adjustor: _____ Adjustor Phone: _____
 Address: _____

Authorization To Release Information: I hereby authorize Southwest Sports Medicine to release any information required in the course of my examination or treatment to the above stated insurance companies:

Signed (Patient Or Parent, If Minor) : _____ Date: _____

Authorization To Pay: I hereby authorize payment directly to the business office of Southwest Sports Medicine for the surgical and/or medical benefits, if any otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection cost and reasonable fees as may be required to obtain collection of this account:

Signed (Patient Or Parent, If Minor) : _____ Date: _____

Cancellation Policy: if I am unable to keep my appointment, I will notify SWSM no later than 24 hours prior to my scheduled appointment. If I fail to notify SWSM, I agree to pay a \$25 cancellation penalty:

Signed (Patient Or Parent, If Minor) : _____ Date: _____