



BUSINESS OFFICE USE ONLY:								
Date:								
Demographics Verified and Insurance & ID Scanned/Verified								
SportsMed Employee's Initials								

Patient's Information

Name (First, MI, Last):			
Street Address:			
City, State and Zip:			
Date of Birth:		Age:	Sex:
Primary Telephone Number: Home Work Cell ()		Secondary Telephone Number: Home Work Cell ()	
<input type="checkbox"/> OK to Leave Message		<input type="checkbox"/> OK to Leave Message	
Social Security Number:			
Email Address:			
How did you hear about us?			
Name of Referring Doctor:		City of Referring Doctor:	

Insurance Information

	Primary Insurance	Secondary Insurance
Name of Insurance Company		
Type of Insurance (Circle One for EACH column:)	PPO POS EPO HMO Medicare Medicaid Auto Insurance Workman's Compensation NONE	NONE PPO POS EPO HMO Medicare Medicaid
ID# or Contract #		
Group #		
Copay Amount \$		N/A
Policyholder's Name		
Policyholder's Birth Date		
Patient's Relationship to Policyholder	Self Spouse Child Other: _____	Self Spouse Child Other: _____

By signing below, I attest that the information listed above is accurate to the best of my knowledge

X _____ _____

Signature of Patient **Date**

or Parent or Legal Guardian if Patient is a **Minor (younger than 18 years old)**

Please continue on next page →

Patient's Name: _____ Patient's Date of Birth: _____

Receipt of Privacy Practices

I hereby acknowledge receipt of the practice's *Notice of Privacy Practices*. *The Notice of Privacy Practices* provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be posted in the practice's offices and will be provided to me upon request. I understand this consent is valid until revoked by me in writing.

Name of Patient's Spouse:	<input type="checkbox"/> OK to discuss information or leave message with spouse
Patient's Emergency Contact Person:	<input type="checkbox"/> OK to discuss information or leave message with this person
Emergency Contact's Daytime Phone Number: ()	

Financial Responsibility

I have received a copy of SportsMed Wheaton Orthopaedics' Financial Policy dated 02/09/07. By signing below, I am agreeing to the terms of the Financial Policy. I understand and agree that it is my responsibility to notify SportsMed Wheaton Orthopaedics of any changes in my health care coverage. I understand and agree that it is my responsibility to contact my insurance company with any questions I have including those about potential benefits and SportsMed Wheaton Orthopaedics' participation with my particular insurance plan. I understand and agree that it is my responsibility to obtain referrals from my PCP if they are required by my plan. I understand and agree that, if I fail to comply with the statements above or the terms of the Financial Policy, any amount unpaid by my insurance plan will be my financial responsibility. I agree to pay for any unpaid balance that is my financial responsibility.

Assignment of Benefits and Authorization to Release Information

I authorize direct remittance of payment for all insurance benefits, including Medicare, if I am a Medicare beneficiary, to SportsMed Wheaton Orthopaedics for all covered services and supplies provided to me during all courses of treatment and care. I authorize the release of any medical or any other information to my insurance carrier(s) or any other entity necessary to determine insurance benefits for related medical services and/or supplies, determine treatment, and other health care operations provided to me by SportsMed Wheaton Orthopaedics. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

By signing below, I attest that the information listed above is accurate to the best of my knowledge.

X _____

Signature of Patient

Date

or Parent or Legal Guardian if Patient is a Minor (younger than 18 years old)

If Patient is a Minor (younger than 18 years old)

Complete the following section listing any and all parties that you are giving permission for SportsMed Wheaton Orthopaedics to discuss information or leave messages with regarding the patient:

Mother's Name: Mother's Telephone Number: Home Work Cell ()	Father's Name: Father's Telephone Number: Home Work Cell ()
Step-Mother's Name: Step-Mother's Telephone Number: Home Work Cell ()	Step-Father's Name: Step-Father's Telephone Number: Home Work Cell ()
Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ()	Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ()