PATIENT INFORMATION FORM

Name____Address______________________________
Last **First** **MI**

City_________________State_____Zip___________Date of Birth_____________Social Security Number___________________

Sex (Male or Female) Marital Status_____________Home Phone_________________Cellular Phone______________

Employer________________________________Employer Phone_______________

Emergency Contact __________________________Phone________________ Email address______________________________

Are we seeing you for an injury or accident? YES or NO (CIRCLE ONE)

Date of accident_____________________ How did accident happen?____
Mth/Day/Year

RESPONSIBLE PARTY INFORMATION (Must be completed if patient is under the age of 18)

Name_______________________________Address__________________________City_____________State____Zip_______
Last **First** **MI**
Home Phone__________________Cellular Phone____________________Date of Birth_____________SS#___________________

Employer ____Employer Phone__________________

Relationship to Patient_____________________________

I AUTHORIZE RELEASE OF INFORMATION FOR MY MEDICAL RECORDS TO THE FOLLOWING:

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WE MUST HAVE A COPY OF YOUR INSURANCE CARD TO FILE YOUR INSURANCE. IF YOU DO NOT HAVE YOUR CARD, YOU WILL BE RESPONSIBLE FOR YOUR BILL AT THE TIME OF YOUR VISIT.

Insurance Assignment of Benefits & Authorization for Release of Information and Consent to Medical Treatment.

I request payment of any medical services and/or benefits rendered by North Miss. Sports Medicine Clinic. I hereby authorize North Mississippi Sports Medicine Clinic to furnish any information to my Insurance carrier(s) and/or any physician concerning my illness or treatment. I understand I am responsible for any amount not covered by my insurance. I hereby voluntary consent to medical care which may include diagnostic procedures and such medical treatment as physician, nurse practitioner and/or any other physician or nurse practitioner providing medical treatment at the clinic considers to be necessary. I authorize use of a photostatic copy of this assignment in lieu of the original when necessary. I do hereby acknowledge receipt of North Mississippi Sports Medicine and Orthopaedic Clinic, PLLC's Notice of Privacy Practice.

Patient/Guardian Signature__________________________________Date____________________

******FOR OFFICE USE ONLY******

WORKERS COMPENSATION VERIFICATION

Approved/Verified by:____

Mail claims to:____

____

Phone Number:____