

PATIENT #
DATE
DOCTOR

**PATIENT INFORMATION**  
Please complete all blanks

**PATIENT**

NAME LAST		FIRST		M.I.		AGE	DATE OF BIRTH	RACE	
ADDRESS				CITY		STATE		ZIP	PHONE
SOCIAL SECURITY NO.		MARITAL STATUS <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE		HAVE YOU BEEN TREATED BY THESE PHYSICIANS BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU SEE THEM FOR THE SAME CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE	
OCCUPATION			NAME OF EMPLOYER OR SCHOOL			PHONE			
EMPLOYER'S ADDRESS				CITY		STATE	ZIP	CELL PHONE	
EMAIL ADDRESS				MAY WE EMAIL PROMOTIONAL /EDUCATIONAL INFORMATION TO YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO					
WHO REFERRED YOU TO OUR OFFICE: <input type="checkbox"/> ANOTHER PATIENT <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> ANOTHER PHYSICIAN <input type="checkbox"/> "DOCTORS"			NAME		ADDRESS				
			<input type="checkbox"/> MED SEARCH <input type="checkbox"/> MEMPHIS VIDEO						
PREFERRED PHARMACY: NAME				TEL.#		DO YOU HAVE AN ADVANCE DIRECTIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHO IS YOUR PRIMARY CARE PHYSICIAN? NAME						ADDRESS		PHONE	
IN CASE OF EMERGENCY NOTIFY:		NAME			STREET ADDRESS, CITY, STATE & ZIP CODE			PHONE	

**RESPONSIBLE PARTY**

NAME		ADDRESS				PHONE	
SOCIAL SECURITY NO.	OCCUPATION		NAME OF EMPLOYER		DATE OF BIRTH		
EMPLOYER'S ADDRESS			CITY		STATE	ZIP	PHONE

**INSURANCE**

PRIMARY INSURANCE	MAIL FORM TO: STREET ADDRESS		CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME		<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.	
SECONDARY INSURANCE	MAIL FORM TO: STREET ADDRESS		CITY	STATE	ZIP	PHONE
POLICY HOLDER (IF GROUP, EMPLOYER)	INSURED'S NAME		<input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE	POLICY OR I.D.#	GROUP OR OTHER NO.	

**PLEASE READ AND SIGN**

**In order to control our costs of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees. A billing fee may be assessed after 60 days.**

**My payment will be made for services rendered by: (please check one)**

- CASH       CHECK       CREDIT CARD

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize Collierville Orthopedic and Sports Medicine. to release any information concerning my treatment and hereby irrevocably assign to them all insurance benefits for my treatment. I am aware that my visit may require orthopedic supplies (DME) and I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage & pre-certifying my benefits with my insurance company. I also understand that I am responsible for reasonable collection costs and / or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

I acknowledge receipt of the Notice of Privacy Practices that was given to me by this Practice. I give my permission to Collierville Orthopedic and Sports Medicine for medical treatment including, but not limited to, examination, injections, blood tests, diagnostic testing or medical procedures deemed necessary and appropriate for diagnosis and treatment.