

# Patient Information Sheet

**Patient Last Name** \_\_\_\_\_ **Patient First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **St** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Soc. Sec. #** \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ **Birth Date** \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_  
**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**Marital Status** \_\_\_\_\_ **Spouse Name** \_\_\_\_\_  
**Spouse's SS#** \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ **Spouse's Birth Date** \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ **Spouse Employer** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**DATE SYMPTOMS BEGAN** (mm/dd/yy) \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_  
How did this happen? \_\_\_\_\_  
Part of the body being seen for \_\_\_\_\_ **Right**  **Left**   
Primary Care Physician: \_\_\_\_\_  
Referred by (if other than Primary Care Physician): \_\_\_\_\_

<b>Did your injury happen on the job?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes, on what date?</b>	_____	
<b>Did you report to your employer?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Is this injury auto accident related?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you have an attorney?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Attorney Name:</b>	_____	

**Primary Insurance** \_\_\_\_\_  
Policyholder's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  Male  Female  
Birth Date \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ ID # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_  
Policyholder's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  Male  Female  
Birth Date \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_ ID # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***If patient is a minor, parent or guardian please complete:***  
Mother \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_  
Father \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

**IN CASE OF EMERGENCY** (Person **NOT LIVING WITH** patient):  
Emergency Contact Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Daytime Phone \_\_\_\_\_

## Insurance Authorization and Assignment of Benefits

I hereby authorize the physicians and physicians' assistants at Bahri Orthopedics and Sports Medicine to treat my illness or injury.

I authorize the release of any medical information necessary to process my claim, and I authorize payment of medical and surgical benefits to Bahri Orthopedics and Sports Medicine. If my insurance company denies payment, I will be responsible for the balance of the account. Co-payments are due at the time of service.

Signature \_\_\_\_\_ Date \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

(If a minor, the parent/legal guardian's signature is required.)