CAPE FEAR SPORTS MEDICINE

Patient Name _____
LAST **FIRST** **MI** **Preferred Name**

Address _____
Street City State Zip Code

Phone (____)_____-_____ (____) _____-_____ (_____) _____-_____
Home Work Cell

Date of Birth _____/_____/_____ **Social Security #** _____-_____-_____ ☐ Male ☐ Female

Race ☐ American Indian ☐ Black or African American ☐ Native Hawaiian ☐ Asian ☐ White ☐ Other

Ethnicity ☐ Hispanic or Latino Ethnicity ☐ Non Hispanic or Latino **Preferred Language** ☐ English ☐ Other _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed **Spouse's Name** _____

Employer_____ **Occupation** _____ ☐ Full Time ☐ Part Time

Student Info ☐ Full Time ☐ Part Time **School Name** _____ **Grade** _____

Referred By _____**Emergency Contact** _____
Name Number

Responsible Party: ☐ Patient ☐ Other: Name _____ Relationship_____

Address _____
Street City State Zip Code

Phone (_____) _____ **Social Security#** _____-____-_____ **DOB**____/_____/_____

Insurance Information **Please give your insurance card and picture ID to the receptionist** **DO NOT LEAVE BLANK**

Primary:_____

Patient's relationship to policy holder
[ ] Self [ ] Spouse [ ] Child [ ] Other_____

Policy Holder Name:_____
Social security _____
Date of Birth: _____/_____/_____

Secondary:_____

Patient's relationship to policy holder
[ ] Self [ ] Spouse [ ] Child [ ] Other_____

Policy Holder Name:_____
Social security _____
Date of Birth: _____/_____/_____

Describe your current problem _____

When did this problem begin?_____ **Were you injured?** Yes_____ No_____ **If yes, when?** _____/_____/_____
Were you injured on the job? Yes_____ No_____ **Auto Accident?** Yes_____ No_____ State of AA:_____

Benefit Assignment / Agreement to Pay:
I hereby authorize my insurance benefits to be paid directly to Cape Fear Sports Medicine. I understand that I am responsible to Cape Fear Sports Medicine for payments made directly to me and for any services or charges not covered by my insurance carrier or out-of-state Worker's Compensation claim. I also understand it is my responsibility to know if Cape Fear Sports Medicine is in network with my insurance carrier.

Authorization to Release Medical Information/ Release for Treatment:
I hereby authorize Cape Fear Sports Medicine to release medical information (which may include treatment for physical / emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS or AIDS-related information) to the patient's insurance carrier and its designated and, in Worker's Compensation cases, to the patient's employer.

*Signature of Patient or Legal Guardian:_____Date:_____