

SOUTHWEST SPORT & SPINE CENTER, INC. PATIENT INFORMATION

PLEASE PRINT CLEARLY

Today's Date: _____

PATIENT INFORMATION (To be completed by patient or responsible party)			
Name:		Sex: M F	Date of Birth:
Mailing Address:		Physical Address:	
City:		City:	
ST:	Zip:	ST:	Zip:
Phone (H): ()	Phone (W): ()	Phone (cell): ()	
E-mail: _____			
Circle one: Insurance Liability W/C			Employer
Marital Status: S M D W		Name:	
Drivers License No.:	ST:	Address:	ST:
Social Security No.:	City:		Phone:()
Referring Doctor:		Phone:()	

Emergency Contact:	Name: _____		
	Relationship:	Phone:()	

TO BE COMPLETED BY RESPONSIBLE PARTY (If other than patient)			
Name:		Relationship to patient: Spouse Child Other	
Address:			
City:	ST:	Zip:	Employer
Phone (H):	Phone (W):	Name:	
Drivers License No.:	ST:	Address:	ST:
SS#:	City:		Phone:()

INSURANCE INFORMATION (Please fill in all blanks)			
Please give us all the information regarding your insurance plan(s). IF YOUR BENEFITS DEPEND ON PRE-AUTHORIZATION, IT IS YOUR RESPONSIBILITY TO INFORM US.			
Primary Insurance:		Secondary Insurance:	
Address:		Address:	
City:	ST:	Zip:	City: ST: Zip:
Insured's Name:		Insured's Name:	
Group No:	Effective Date:	Group No:	Effective Date:
ID No:		ID No:	
Plan No:	Plan No:		
If work related , Date of Injury:		Case Manager:	Phone:()

Signature of Patient or Authorized Person	
I hereby authorize release of medical information necessary to report a claim to my plan(s). The above information is current and true to the best of my knowledge. A copy of this signature is valid as the original.	
Signed: _____	Date: _____

PLEASE REVIEW OUR OFFICE FINANCIAL POLICY ON THE NEXT PAGE

IF THE FREQUENCY OF CO-PAYMENTS BECOMES A PROBLEM IN ACHIEVING YOUR PHYSICAL THERAPY GOALS/NEEDS, THEN PLEASE ASK ABOUT OUR CO-PAYMENT POLICY