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 O F O Date of Birth:
Mailing Address:	Physical Address:
City:	City:
ST: Zip:	ST: Zip:
Phone (H): ( ) Phone (W): ( )	Phone (cell): ( )
E-mail:	
Circle one: Insurance O Liability O W/C O	**Employer**
Marital Status: S O M O D O W O	Name:
Drivers License No.: ST:	Address: ST:
Social Security No.:	City: Phone:( )
Refering Doctor:	Phone:( )
Emergency Contact: Name:	
Relationship:	Phone:( )

TO BE COMPLETED BY RESPONSIBLE PARTY (If other than patient)

Name:	Relationship to patient: O Spouse O Child O 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