

**EAST BAY SPORTS MEDICINE
NEW PATIENT FORM**



DATE: _____

REFERRED BY: _____

PATIENT'S NAME: (last) _____ (first) _____ (m.i.) _____

ADDRESS: _____ APT# _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ CELL PHONE: () _____ SS#: _____

SEX: _____ DOB: _____ AGE: _____ HT: _____ WT: _____ DL#: _____

EMPLOYER: _____ PHONE: () _____

ADDRESS: _____ DEPT: _____

OCCUPATION: _____

SPOUSE/RELATIVE: _____ RELATIONSHIP: _____

HOME ADDRESS: _____ PHONE: () _____

EMPLOYER: _____ PHONE: () _____

ADDRESS: _____

OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____

NAME OF ANY SPECIALIST YOU HAVE SEEN OR ARE SEEING: _____

RESPONSIBLE PARTY IF PATIENT IS UNDER 18 YEARS OF AGE

FULL NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____ DL#: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE# () _____

EMPLOYER: _____ WK PHONE# () _____

ADDRESS: _____ SS#: _____

PERMISSION TO TREAT MINOR

I/We give consent to have my child receive the necessary medical treatment as prescribed by their doctor. _____

SIGNED (PARENT OR GUARDIAN)

Date



IS PATIENT'S CONDITION RELATED TO:

A) EMPLOYMENT? YES () NO ()

IF YES, NAME OF EMPLOYER: _____

B) AUTO ACCIDENT? YES () NO () DATE AND TIME OF INJURY/ACCIDENT: _____

C) OTHER ACCIDENT? YES () NO () DATE AND TIME OF INJURY/ACCIDENT: _____

IF YES, PLEASE EXPLAIN: _____

PRIMARY INSURANCE:

INSURANCE COMPANY NAME: _____

INSURED'S NAME _____ ID#: _____ GROUP/POLICY# _____

INS. COMPANY ADDRESS: _____ PHONE() _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME: _____

INSURED'S NAME _____ ID#: _____ GROUP/POLICY# _____

INS. COMPANY ADDRESS: _____ PHONE() _____

RELATIONSHIP TO PATIENT: _____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process my claims. I also request payment of medical benefits to either myself or the party who accepts assignment below.

SIGNED (PATIENT OR GUARANTOR) Date

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby instruct my insurance company (primary or secondary) to pay directly to my physician any benefits allowable for his professional services rendered to me.

SIGNED (PATIENT OR GUARANTOR) Date

RESPONSIBILITY OF UNPAID BALANCE:

I SHALL BE RESPONSIBLE FOR ANY BALANCE NOT PAID DUE TO CO-PAYMENTS, DEDUCTIBLES, DENIED CLAIMS OR UNCOVERED SERVICES.

SIGNED (PATIENT OR GUARANTOR) Date