WELCOME TO OUR OFFICE – ATHLETIC INSTITUTE OF MEDICINE, INC.

GENERAL PATIENT INFORMATION The information is necessary for our files and will be considered confidential

□NEW PATIENT □UPDATE (REQUIRED YEARLY)

Patient's Last Name _____ First Name _____ Middle _____ Date of Birth _____ Social Security Number _____

Local Address _____ Apt/Lot# _____ City _____ State _____ Zip _____

SEX: □Female □ Male Marital Status: □Single □Married □Widowed □Separated □Divorced

Mailing Address/Permanent Address – if different than local address _____

Home Telephone # _____ Work Telephone # _____ Cellular Telephone # _____ E-mail address _____

Employed by _____ Employer's Address _____ State _____ City _____ Zip _____

Occupation _____ Status: □Full Time □Part Time □Other: _____

Primary Care Physician (PCP) _____ Address _____ City _____ State _____ Zip _____ Phone Number _____

Referring Physician _____ Address _____ City _____ State _____ Zip _____ Phone Number _____

SPOUSE INFORMATION

Name Last _____ First _____ Middle _____ Date of Birth _____ Social Security Number _____

Spouse's Employer _____ Address _____ City _____ State _____ Zip _____ Work Phone _____

IF THE PATIENT IS A MINOR OR STUDENT

STATUS: □ Full Time □Part Time

1. _____ _____ _____ _____
If patient is a minor, who may authorize treatment Relationship DOB SS#
Home phone_____ Work Phone _____ Cellular Phone _____

2. _____ _____ _____ _____
If patient is a minor, who may authorize treatment Relationship DOB SS#
Home phone_____ Work Phone _____ Cellular Phone _____

IN CASE OF EMERGENCY

_____ _____ _____
Name of person to notify in case of emergency other than spouse Relationship Emergency Phone

_____ _____ _____ _____
Address City State Zip

COMPLETE THIS SECTION IF WORK RELATED INJURY

INDUSTRIAL CARRIER: _____ DATE OF INJURY: _____

CLAIM ADDRESS: _____ CITY _____ STATE _____ ZIP _____

CLAIM NUMBER: _____ CASE WORKER: _____ TELEPHONE #: _____

**********TURN PAGE OVER**********

INSURANCE INFORMATION **Please complete and we will need a copy of your Insurance Card**

_____ _____ **Is this through employer** □ **Yes** □ **No**

PRIMARY **Insurance Company Name** **Telephone Number**

_____ _____ _____ _____

Claim Address **City** **State** **Zip**

Insured's ID Number (Policy No.): _____ **Group Number:** _____ **Effective Date:** _____

_____ _____ _____

Insured's Name Last First Middle **Insured's SS#** **Insured's DOB**

Insured's Relation to Patient □**Self** □**Spouse** □**Parent** **COPAY Amount DUE:** _____

_____ _____ **Is this through employer** □ **Yes** □ **No**

SECONDARY **Insurance Company Name** **Telephone Number**

_____ _____ _____ _____

Claim Address **City** **State** **Zip**

Insured's ID Number (Policy No.): _____ **Group Number:** _____ **Effective Date:** _____

_____ _____ _____

Insured's Name Last First Middle **Insured's SS#** **Insured's DOB**

Insured's Relation to Patient □**Self** □**Spouse** □**Parent** **COPAY Amount DUE:** _____

PLEASE READ AND SIGN ALL AREAS BELOW

FINANCIAL POLICY UNDERSTANDING I understand and agree, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information above.

I agree to pay all costs of a collection agency if necessary to obtain payment. Should legal action be needed to collect an unpaid balance due, I agree to pay attorney's fees and costs the court deems proper.

Transactions shown on the monthly statement are agreed to be correct and reasonable unless written notice is made within thirty (30) days of the billing date. I agree to pay a $10.00 monthly maintenance fee applied to accounts with charges unpaid after sixty (60) days.

I hereby authorize my insurance benefits to be paid directly to Athletic Institute of Medicine, Ltd.

Authorization to release information: I hereby authorize Athletic Institute of Medicine, Ltd. to release any medical records necessary for payment of any health or disability claim.

Patient's Signature or Parent if minor _____ Date: _____