

PATIENT INFORMATION

Today's Date: _____ Referred By: _____
First Name: _____ MI: _____ Last Name: _____
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Primary Phone: () _____ Type: _____ Secondary Phone: () _____ Type: _____
Third Phone: () _____ Type: _____ E-mail address: _____
DOB: _____ SS#: _____ Marital Status: S M D W Sex: M F
Employer Name: _____ Occupation: _____
Emp. Address: _____ City: _____ State: _____ Zip: _____
Name of Spouse/Parent: _____ Home Phone: () _____
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Spouse/Parent Employer: _____ Work Phone: () _____
Emergency Contact: _____ Relation: _____ Phone: () _____

INSURANCE INFORMATION

Primary Insurance Plan: _____
Circle One: HMO PPO Workers Comp Other _____
Primary Care Physician: _____ Medical Group: _____ Ins Phone: () _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Policyholder: _____ DOB: _____ Relation to Patient: _____
Insurance ID#: _____ Group #: _____ Policyholder SS#: _____

Secondary Insurance Plan: _____
Circle One: HMO PPO Workers Comp Other _____
Primary Care Physician: _____ Medical Group: _____ Ins Phone: () _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Policyholder: _____ DOB: _____ Relation to Patient: _____
Insurance ID#: _____ Group #: _____ Policyholder SS#: _____

Assignment of Benefits, Eligibility Guarantee and Missed Appointment Policy

I request that payment of authorized insurance benefits be made on my behalf to San Diego Sports Medicine and Family Health Center (SDSMFHC) for any services rendered. I authorize SDSMFHC to release to my insurance plan and its agents any information needed to determine these benefits. I hereby certify that I am eligible for the above named health plan and, if applicable, have chosen a physician from SDSMFHC to be my primary care physician. I understand that if I am not eligible under the terms of my health plan, I am liable for all charges for services rendered. I also agree to pay in full for all non-covered services within 30 days of notification of non-coverage. I understand that SDSMFHC will charge a \$30.00 fee for missed appointments scheduled that are not cancelled with at least 24 hours notice.

Signature of Patient or Parent/Guardian/Policyholder

Date

CONTINUED ON REVERSE