

IDAHO SPORTS MEDICINE INSTITUTE

PATIENT: _____ REFERRED BY: _____
(LAST NAME) (FIRST NAME) (M.I.) (COACH/TRAINER/MD/FRIEND, etc.)

CURRENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____ SPOUSE'S NAME: _____

HOME PHONE: () _____ CELL: () _____ SOCIAL SECURITY #: _____

PATIENT'S EMPLOYER: _____ BUSINESS PHONE: _____

SPOUSE EMPLOYER: _____ BUSINESS PHONE: _____ SSN: _____

PATIENT IS A STUDENT full-time or part-time ?

NAME OF RESPONSIBLE PARTY: _____ Relationship: _____
(If patient is a child or student)

RESPONSIBLE PARTY'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Father's Name: _____ SSN: _____ Employer: _____ Wk Phone: _____
(If Child)

Mother's Name: _____ SSN: _____ Employer: _____ Wk Phone: _____
(If Child)

IN CASE OF EMERGENCY: _____ Relationship: _____ Phone: _____
Contact Person (NOT LIVING WITH YOU)

INSURANCE INFORMATION

**** POLICYHOLDER/SUBSCRIBER NAME: _____ **DOB: _____**

- IF WE GET A (FRONT/BACK) COPY OF YOUR CARD YOU DO NOT NEED TO FILL THIS SECTION OUT -

PRIMARY INSURANCE CO.: _____ SUBSCRIBER: _____

SUBSCRIBER/POLICY #: _____ GROUP: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE CO.: _____

POLICY HOLDER/SUBSCRIBER NAME: _____ DOB: _____

SUBSCRIBER/POLICY #: _____ GROUP: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REASON FOR VISIT

WERE YOU INJURED ON THE JOB? _____ IF SO, PLEASE GIVE Date of INJURY: _____

Has this been reported to your employer? _____ other doctor(s) on case? _____

Name of Industrial Carrier: _____ ID/Case #: _____

WHAT WILL THE DOCTOR BE EXAMINING? (Please indicate Right or Left) _____

IF ACCIDENT OR INJURY, GIVE DATE OF INJURY: _____ and BRIEF DESCRIPTION: _____

****MEDICATION ALLERGIES: _____ ****CURRENT MEDICATIONS: _____

LIST YOUR SPORTS AND FITNESS ACTIVITIES: _____

PLEASE READ AND SIGN : All professional services rendered are charged to the patient. If you have supplied us with insurance information, we will help you file a claim. The patient is responsible for all fees, regardless of insurance coverage and flexible spending accounts. Please remember that you carry the insurance and we cannot accept blame for lack of coverage or slow payment by the insurer. It is customary to pay any co-pay, deductible or percentage amount due at the time of service unless advance arrangements have been made. A payment must be made on the balance every 30 days. Balances over 90 days will be charged 1% interest with a minimum of \$2.00 monthly.

I understand the above statement and agree to its content. I hereby authorize the Idaho Sports Medicine Institute (ISMI) to render treatment. I further authorize ISMI to release any medical records to my insurance carrier to facilitate processing and authorize my insurance carrier to pay all benefits directly to ISMI. I understand that ISMI has a Privacy Notice regarding my confidential medical information. I further acknowledge that I may view the policy in the waiting room, during normal business hours, or may request a copy from the Privacy Officer at (208) 336-8250.

DATE: _____ SIGNATURE: _____

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN. PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)