

FORGEY SPORTSMED & REHAB CLINIC, PLLC

1503 NE 78th St., Ste. # 9, Vancouver, WA 98665 360-573-5500 360-573-9075 Fax www.sportsmedonline.net

PATIENT INFORMATION

Name: _____
LAST FIRST MI

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS #: _____

Home Address: _____ Apt. #: _____

CITY STATE ZIP

Single Married Divorced Widow Separated Student

Hm #: () _____ Pager/Cell #: _____

Wk #: () _____ Ext: _____ DL#: _____

Employer: _____

Employer's Address: _____

Occupation: _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Email Address: _____

Were you offered the option to fill out paperwork online? Yes No

SPOUSE/GUARDIAN INFORMATION

His/Her Name: _____

Employer: _____

Wk #: () _____ Cell #: _____

Birthdate: ____/____/____ SS #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relation to patient: _____

SS #: _____ Hm #: _____

Cell #: _____ Wk #: () _____

Billing address: _____

In the event of an emergency, is there a nearest relative (not living with you) that we should contact?

His/Her Name: _____

Relation: _____

Home #: () _____ Wk #: () _____

INSURANCE COVERAGE

Primary Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Insured's Name: _____ Relation: _____

Insured's ID #: _____ Gr. #: _____

Insured's Birthdate: ____/____/____

Insured's Employer: _____

Secondary Insurance

Name: _____ Relation: _____

ID #: _____ Group #: _____

Insured's Birthdate: ____/____/____

Insured's Employer: _____

I certify that this information is true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary in accordance with state statutes for the care and management of my complaints. I understand and agree that I am ultimately responsible for payment and that co-pays are due at the time of service. I acknowledge that I have been given a copy of this office's privacy policy and have read and understand the policy.

Signature

Date