

**FORGEY SPORTSMED & REHAB CLINIC, PLLC**

1503 NE 78<sup>th</sup> 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: \_\_\_\_\_

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 #: ( ) \_\_\_\_\_

**AUTO INSURANCE INFO**

**PATIENT'S AUTO INSURANCE (PIP)**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim Adjuster's Name: \_\_\_\_\_

City & State the accident occurred in: \_\_\_\_\_

Date of Motor Vehicle Accident: \_\_\_\_\_

**PARTY AT FAULT INSURANCE**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insured's Name: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim Adjuster's Name: \_\_\_\_\_

Was the Accident your fault? YES NO

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. I acknowledge that I have been given a copy of this office's privacy policy and have read and understand the policy.

Signature

Date