

New Patient Form

Total Sports Care, P.C.

Date _____

Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ include area code Cell Phone _____ include area code

Sex _____ Birth Date _____ mm/dd/yyyy Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____

Patient's Employer _____ Occupation _____ Work Phone _____ include area code

Spouse's Name _____
Last Name First Name Middle Name Name goes by

Spouse's Employer _____ Occupation _____ Work Phone _____ include area code

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____ include area code

Referred By

Referred By _____

Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I have received a copy of the practice's Privacy Notice and the Financial and Office Policies and agree to follow to the policies.

Signature _____ Date _____

I hereby authorize Total Sports Care, P.C. /Brian Cost, M.D., P.C./Jeff Garrard, M.D., P.C. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Total Sports Care, P.C., Brian Cost, M.D., P.C., Jeff Garrard, M.D., P.C. or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____