

THE ORTHOPAEDIC & SPORTS INJURY CENTER

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_  
CITY \_\_\_\_\_ SOCIAL SECURITY NO \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMPLOYER'S NAME \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
EMERGENCY NAME \_\_\_\_\_ EMERGENCY PHONE # \_\_\_\_\_  
SEX: M \_\_\_\_\_ F \_\_\_\_\_ RACE: \_\_\_\_\_

MARITAL STATUS: (CHECK ONE) S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ SEP \_\_\_\_\_ W \_\_\_\_\_  
SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S SSN# \_\_\_\_\_  
SPOUSE'S EMPLOYER \_\_\_\_\_ SPOUSE'S WORK # \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INS. \_\_\_\_\_ SECONDARY INS \_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER NAME \_\_\_\_\_  
SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

**IF PATIENT IS A MINOR : SUBSCRIBER NAME** \_\_\_\_\_  
**BIRTHDATE** \_\_\_\_\_ **SS#** \_\_\_\_\_  
**FATHER'S NAME** \_\_\_\_\_ **SS#** \_\_\_\_\_  
**EMPLOYER** \_\_\_\_\_ **WORK #** \_\_\_\_\_  
**MOTHER'S NAME** \_\_\_\_\_ **SS#** \_\_\_\_\_  
**EMPLOYER** \_\_\_\_\_ **WORK#** \_\_\_\_\_

**PLEASE GIVE INSURANCE CARDS AND DRIVERS LICENSE TO RECEPTIONIST**

**IS THIS VISIT COVERED BY WORKMANS COMPENSATION?** \_\_\_\_\_  
**IF SO, AUTHORIZED BY WHOM?** \_\_\_\_\_

**FOR ALL PATIENTS: READ AND SIGN:**  
**I HEREBY GIVE DR C. THOMAS HOPKINS, JR. OR DR A.BRUCE REID PERMISSION TO TREAT ME OR MY CHILD AS HE SEES MEDICALLY FIT, AND TO RELEASE ANY PERTINENT INFORMATION TO MY INSURANCE COMPANY, HOSPITAL OR OTHER PHYSICIANS. I HEREBY AUTHORIZE INSURANCE BENEFITS TO BE PAID TO THE ORTHOPAEDIC AND SPORTS INJURY CENTER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.**

**SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**A FEE OF 25.00 WILL BE CHARGED FOR ALL CANCELLED AND NO SHOW APPTS., UNLESS 24 HRS NOTICE IS GIVEN.**