

# HILL COUNTRY SPORTS MEDICINE

(Please Print Information)

Checked in by \_\_\_\_\_

X-Rays  YES  NO

**Fill in all Blanks**

Date \_\_\_\_\_

DOCTOR'S NAME		FAMILY PHYSICIAN		REFERRED BY:		NAME OF SCHOOL AND REFERRING COACH	
PATIENT NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY #		SEX M. or F.	MARITAL STATUS
ADDRESS				PHONE		AGE	DOB:
CITY-STATE-ZIP				CELL # / PAGER #		OCCUPATION	
PROBLEM / COMPLAINT		RIGHT	LEFT	DATE OF ONSET	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	AUTO <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER <input type="checkbox"/> YES <input type="checkbox"/> NO

IN YOUR OWN WORDS WHEN, WHERE, AND HOW DID YOU PROBLEM OR ACCIDENT HAPPEN OR BEGIN (IF MORE SPACE IS NEEDED, USE THE BACK SIDE)

PERSON RESPONSIBLE FOR BILL		RELATIONSHIP		SOCIAL SECURITY #		PHONE	
TDL #	ADDRESS			CITY-STATE-ZIP			
EMPLOYER NAME			ADDRESS			PHONE	
IN CASE OF EMERGENCY NOTIFY				RELATIONSHIP		PHONE	

### INSURANCE DATA

WORKMAN'S COMP   
  COMMERCIAL   
  HMO   
  PPO

INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

FAX # \_\_\_\_\_

**OFFICE USE ONLY**

**INSURANCE VERIFICATION**

DATE OF INJURY: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

DEDUCTIBLE MET  YES  NO

DEDUCTIBLE AMT. \_\_\_\_\_

CO-PAY AMT. \_\_\_\_\_

PERSON TO CONTACT TO VERIFY  
\_\_\_\_\_

CLAIM #: \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

In the event this claim is denied by workman's comp or my insurance company I understand that I am responsible for all charges incurred as a result of this visit. I hereby authorize the above physician to release information to my employer and insurance carrier. I hereby authorize payment directly to the above provider of the surgical and or medical benefits if any, otherwise payable to me for his services, but not exceed the reasonable and customary charge for all those services. I understand that this authorization does not release me from my personal responsibility for payment of all charges.

**Signed (Patient or Insured) (Parent signature required for minor)**

Signature \_\_\_\_\_

Date \_\_\_\_\_