Sports and Spine Orthopaedics

Patient Demographic and Insurance Information

(Please type or print legibly)

Chart #___________________ **Physician**________________________ **Date**_______________

Patient name (LAST)___________________________________(FIRST)_______________________(MIDDLE)_______________
Social Security #__________________________________Drivers License#________________________ State_______________
Date of Birth:__________________ Age:___________ Sex ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W
Address:____City:_________________________ State:____________ Zip:__________
Mailing Address: ☐ Same as above
Address:____City:_________________________ State:____________ Zip:__________
Home Phone:_____________________________________ Business Phone:____
Cell Phone:_______________________________________ Email: ____
Emergency Contact:_____________________________Relationship:____________________ Phone: ______________________
Address:____City:_________________________ State:____________ Zip:__________

Date of Injury:____________________________________ If not injury, when did pain begin_______________________
Reason for Visit:___________________________________ Body part:______________________ ☐ R ☐ L
How did you hear about our office? ☐ Website ☐ Social media ☐ Magazine ☐ Emergency room/urgent care
☐ Primary care doctor ☐ Current patient ☐
Other______________________________

<u>Insurance</u>

Primary:____ Secondary:____
Name of Insured: _________________________________ Name of Insured:____________________________________
SS#____ SS#:____
Date of Birth:_____________________________________ Date of Birth:_______________________________________
Relationship: ☐ Self ☐ Spouse ☐ Other Relationship: ☐ Self ☐ Spouse ☐ Other

Is this is a workman's compensation/personal injury claim? ☐ Yes ☐ No *If yes, please complete below*
Insurance Company:____ Date of Injury:______________________
Adjuster's Name:____ Claim #:____________________________
Phone:____ Fax:____

<u>If Patient is a Minor or a Student</u>

School Name, Address and Phone:____
Father's Name:____Date of Birth:__________________________
Address:____City:_________________________ State:____________ Zip:__________
Employer:____Phone:____________________________________
Mother's Name:____Date of Birth:__________________________
Address:____City:_________________________ State:____________ Zip:__________
Employer:____Phone:____________________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Sports and Spine Orthopaedics or insurance company to release any information required to process my claims, determine the benefits payable fir related equipment or services to the organization, the Health Care financing administration. A copy of this authorization will be send to the Health Care financing Administration, my insurance company or other entity if requested. I, the above listed, authorize and direct the above listed insurance company to pay by check, made out and mailed to Sports and Spine Orthopaedics c/o Peter S. Borden MD 23456 Hawthorne Blvd, Suite 200 Torrance CA 90505. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the above mentioned insurance company to make the check to me and mail it as follows: Sports and Spine Orthopaedics c/o Peter S. Borden MD 23456 Hawthorne Blvd, Suite 200 Torrance CA 90505.

If the patient is less than 18 years of age, guarantor must sign.

Signature of Financially Responsible Party:____
Relationship to Patient:____ Date:_______________________