FLORIDA SPORTSMEDICINE AND ORTHOPAEDICS, P.A.
REGISTRATION FORM

Date:_____
Patient:_____
Last First Middle
Address: _____
Street City State Zip
Sex: ____M ____F Marital Status: ___Single ___Married ___Widowed ___Divorced

Date of Birth: _____ SSN: _____ Age: _____

Home Phone #: _____ Work Phone #: _____

Occupation: _____ Employer: _____

Spouse/Guardian: _____ Work Phone #: _____

In Case of Emergency: _____ Relation: _____ Phone #: _____

Insurance Information

Do you have insurance? _____Yes _____No
____ Medicare ____Medicaid ____Tricare ____Work Comp ____BCBS ____Other
Primary Company:_____ Insured: _____
Relationship: _____ Policy #_____ Group #: _____

Secondary (if any): _____ Insured: _____
Relationship: _____ Policy# _____ Group #: _____

Visa Card # _____ Exp. Date: _____
Master Card # _____ Exp. Date: _____
I acknowlege full financial responsibility for services rendered by Florida Sportsmedicine And Orthopaedics, P.A. and authorize transfer of all unpaid amounts to my Visa/Mastercard after 90 days from the date of service.
Signature: _____ Date: _____
Any copayment, deductible or portion of your bill that is not covered by your insurance company will be due each visit AT THE TIME OF SERVICE.

Purpose of Today's visit

Purpose of Today's visit? _____ Left or Right
Was this related to an accident? Yes No If Yes….
Date of Accident: _____ Where did the accident occur? _____
Describe Accident: _____

Who may we thank you for referring you: _____ Phone #_____
***** We will need a copy of your driver's license and any insurance cards you may have.