FLORIDA SPORTSMEDICINE AND ORTHOPAEDICS, PA
REGISTRATION FORM

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ I wish to be contacted by (circle one) email, text, home phone, cell phone.

Pharmacy: _____ Location: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Sex: ____Male ____Female Marital Status: ____Single ____Married ____Widowed ____Divorced

How did you hear about our office? Newspaper, Internet, Magazine, Friend_____ Doctor_____

Insurance Information:

Primary Ins Co: _____ Policy Number: _____ Group #: _____

Secondary Ins Co: _____ Policy Number: _____ Group #: _____

Race: ____White ____American Indian ____Asian ____African American ____Hawaiian

Ethnicity: ____ Hispanic ____Non Hispanic **Language:** ____English ____Spanish ____Other

Is this related to an accident? Yes No ____Auto ____Worker's Comp ____Other

Injury Date: _____ Body Area Involved: _____

How did the accident happen?_____

Is an attorney involved: ____Yes ____No If yes – Attorney's Name: _____

Please list any family/friends that you authorize Florida Sportsmedicine and Orthopaedics to release your medical and insurance information to.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Authorization and Release:

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I authorize and request my insurance company to pay directly to Florida Sportsmedicine and Orthopaedics insurance benefits otherwise payable by me. I understand that my insurance carrier may pay less than the actual billed amount. I agree to be responsible for payment of all services rendered.