

FOOTHILLS SPORTS MEDICINE
PATIENT REGISTRATION FORM
Please Print

Patient Name: _____ Patient Social #: _____

Gender: Male Female Birth Date: _____ Age: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Other: _____ Email: _____

Parent/Guardian: _____ Parent/Guardian Social #: _____

Relationship to Patient: _____ Parent/Guardian Birth Date: _____

Primary Physician: _____

Occupation: _____ Date of Injury: _____

Employer/School/Team Name: _____

Address / City, State, Zip: _____

Emergency Contact: _____ Relationship/Phone: _____

How did you hear of Foothills Sports Medicine?:

Referred by Doctor Friend or Family Yellow Pages Other: _____

Insurance Information (*Please provide insurance card*)

Primary Insurance

Secondary Insurance

Insurance Name: _____

Insurance Name: _____

Policy Holder: _____

Policy Holder: _____

Policy Holder Social #: _____

Policy Holder Social #: _____

Policy Holder Birth Date: _____

Policy Holder Birth Date: _____

Relationship to Patient: _____

Relationship to Patient: _____

Policy Holders Employer: _____

Policy Holders Employer: _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Foothills Sports Medicine to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian) _____ Date _____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Foothills Sports Medicine, _____, for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian) _____ Date _____