South Bay Sports & Preventive Medicine Associate, Inc.

550 S. Winchester Blvd. Suite 100, San Jose, CA 95128

Date: _____

Patient's Name: _____ Gender: Male / Female

Birthdate: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # ( ) _____ Cell# ( ) _____

Email Address _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Emergency Contact Name & Phone # _____ Relationship _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone # ( ) _____ Best Number to reach you? ☐ Home ☐ Work ☐ Cell

INSURANCE: PRIMARY (Self/Spouse/Parent)

Insurance Name: _____

Insured Name: _____

Birthdate: _____

I.D. #/Policy# _____

Group/Plan# _____

Effective Date: _____

INSURANCE: SECONDARY (Self/Spouse/Parent)

Insurance Name: _____

Insured Name: _____

Birthdate: _____

I.D. #/Policy# _____

Group/Plan# _____

Effective Date: _____

ASSIGNMENT AND RELEASE

I understand I am financially responsible for co-payments, deductibles, co-insurance percentages And any non-covered services by my health plan AT TIME OF SERVICE. (initials) _____

I authorize the physician to release any medical information required in order claim processing. _____

I hereby authorize my insurance benefits to be paid directly to the undersigned physician. _____

Signed _____ Date _____

Thank You!

SPORTS ORTHOPEDIC AND REHABILITATION MEDICINE ASSOCIATES

THE PHYSIATRY MEDICAL GROUP

HIPPA

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices of
Sports Orthopedic and Rehabilitation Medicine Associates
and
The Physiatry Medical Group, Inc.

I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my next appointment.

_____

Patient Signature

_____

Patient Name – Printed

_____

Date MRN