



Who referred you to Florida Sports Medicine Institute?

Patient Information:

Last Name: _____

First Name: _____ MI: _____

Street Address: _____

City/State: _____ / _____ Zip: _____

E-Mail Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Date of Birth: ____/____/____ Social Security #: ____/____/____

Marital Status: _____

Employer Name: _____

Street Address: _____

City/State: _____ / _____ Zip: _____

Emergency Contact: _____

Telephone: _____

Person Responsible for Bill:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City/State: _____ / _____ Zip: _____

Insurance Information:

Primary Insurance Co: _____

Telephone #: _____

Policy Number: _____

Group Number: _____

Insured's Name: _____ Date of Birth: _____

Relation to Patient: _____

Secondary Insurance Co: _____

Telephone #: _____

Policy Number: _____

Group Number: _____

Insured's Name: _____ Date of Birth: _____

Relation to Patient: _____

Injury Date: _____ **Body Area Involved:** _____

Location of Accident: _____

Is an attorney involved: Yes/NO, If yes please provide name and number: _____

Authorization and Release:

I authorized 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 FSMI insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered.

Patient/Guarantor Signature

Date