IDAHO SPORTS MEDICINE INSTITUTE

PATIENT:____ REFERRED BY:__________
(LAST NAME) (FIRST NAME) (M.I.) (COACH/TRAINER/MD/FRIEND, etc.)

CURRENT ADDRESS:______________________ CITY:__________ STATE:_____ ZIP:__________

DATE OF BIRTH:__________ AGE:______ SEX:_____ HEIGHT:______ WEIGHT:______ BLOOD PRESSURE:_____/_____

HOME PHONE:( )__________ CELL:( )__________ SOCIAL SECURITY #:__________

PATIENT'S EMPLOYER:______________________ BUSINESS PHONE:______________

PATIENT IS A STUDENT: full-time or part-time PREFERRED LANGUAGE:______________

Required by the government to meet meaningful use criteria:

RACE: (circle) American Indian or Alaska Native Asian Black/African American White Native Hawaiian or Other Pacific Islander Other: __________

ETHNICITY: (circle) Hispanic Non-Hispanic Other:__________

MARITAL STATUS:_____ SPOUSE'S NAME:______________ SSN:__________ DOB:__________

SPOUSE EMPLOYER:______________ CELL:__________ BUSINESS PHONE:__________

NAME OF RESPONSIBLE PARTY:______________________ Relationship:__________
(If patient is a child or student)

RESPONSIBLE PARTY'S ADDRESS: ______________________ CITY:__________ STATE:_____ ZIP:__________

Father:__________ DOB:__________ SSN:__________ Employer:__________ Phone:__________
(If child or covered under parent's insurance)

Mother:__________ DOB:__________ SSN:__________ Employer:__________ Phone:__________
(If child or covered under parent's insurance)

IN CASE OF EMERGENCY:______________________ Relationship:__________ Phone:__________
Contact Person (NOT LIVING WITH YOU)

REASON FOR VISIT

WERE YOU INJURED ON THE JOB?__________ IF SO, PLEASE GIVE Date of INJURY:__________

Has this been reported to your employer?__________ other doctor(s) on case? __________

Name of Industrial Carrier:______________________ ID/Case #:__________

WHAT WILL THE DOCTOR BE EXAMINING? (Please indicate Right or Left)______________________

IF ACCIDENT OR INJURY, GIVE *DATE OF INJURY:*__________ and BRIEF DESCRIPTION:______________________

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****MEDICATION ALLERGIES:______________ ****CURRENT MEDICATIONS:______________

PHARMACY NAME & LOCATION:______________________ PHONE:__________

LIST YOUR SPORTS AND FITNESS ACTIVITIES:______________________

INSURANCE INFORMATION
(Front/Back copy of insurance card(s) is required at time of service)

Insurance Company Name/Address	Policy ID#/Group#	Policy Holder/Subscriber Name	Relationship to Patient

PLEASE READ AND SIGN : All professional services rendered are charged to the patient. If you have supplied us with insurance information, we will help you file a claim. The patient is responsible for all fees, regardless of insurance coverage and flexible spending accounts. Please remember that you carry the insurance and we cannot accept blame for lack of coverage or slow payment by the insurer. It is customary to pay any co-pay, deductible or percentage amount due at the time of service unless advance arrangements have been made. A payment must be made on the balance every 30 days. Balances over 90 days will be charged 1% interest with a minimum of $2.00 monthly.

I understand the above statement and agree to its content. I hereby authorize the Idaho Sports Medicine Institute (ISMI) to render treatment. I further authorize ISMI to release any medical records to my insurance carrier to facilitate processing and authorize my insurance carrier to pay all benefits directly to ISMI. I understand that ISMI has a Privacy Notice regarding my confidential medical information. I further acknowledge that I may view the policy in the waiting room, during normal business hours, or may request a copy from the Privacy Officer at (208) 336-8250.

DATE:__________ SIGNATURE:______________________________

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN. PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)