

**WELCOME TO
SPORT Clinic of Greater Milwaukee, Inc.**

G E N E R A L	Patient Name: _____ Address: _____ City: _____ State, Zip: _____ Home Phone: _____ Work Phone: _____ Birthdate: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Social Security #: _____ Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D Employer: _____ Retired: " Yes Occupation: _____ What made you choose SPORT Clinic? <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Previous patient <input type="checkbox"/> Web site <input type="checkbox"/> Doctor <input type="checkbox"/> Other—explain _____ Person to Notify in Case of Emergency: _____ Name: _____ Phone: _____ Referred By: Dr. _____ Primary Physician: _____	Today's Visit is the Result of: <input type="checkbox"/> Motor Vehicle Accident Do you want SPORT Clinic West to bill auto insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please Fill Out Info on Back of Form) <input type="checkbox"/> Workers' Compensation Injury Do you want SPORT Clinic West to bill Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, Please Fill Out Info on Back of Form) <input type="checkbox"/> Other Type of Accident (Please Explain) What will we be treating today? <input type="checkbox"/> Knee <input type="checkbox"/> Back <input type="checkbox"/> Shoulder <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Ankle/Foot <input type="checkbox"/> Other: _____ Responsible Party if Minor: (Person responsible for balance after insurance) Name: _____ Address: _____ City: _____ State, Zip: _____
	I N S U R A N C E	Primary Insurance Co.: _____ Subscriber Name: _____ Subscriber ID #: _____ Group ID #: _____ Subscriber's Employer: _____ Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Subscriber's Birthdate: _____
F I N A N C I A L	PAYMENT ASSIGNMENT: I authorize the release of information for the purpose of payment of benefits, and authorize payment directly to SPORT Clinic of Greater Milwaukee Inc. for services rendered to myself and/or my dependents. I understand that in the event that my medical bills are not paid in full by my insurance, I am financially responsible for any unpaid balance.	
	CONSENT TO TREAT: I authorize SPORT Clinic of Greater Milwaukee Inc. to perform physical therapy. Signature of Patient (Guardian if a minor): _____ Date: _____	
	Would you like to receive our patient newsletter with helpful tips on healthy living? If yes, please write e-mail address: _____	

WORKERS' COMPENSATION INSURANCE INFORMATION

Please fill out the top of this form if the injury is work related

Insurance Company _____

Address _____

City _____ **State** _____ **Zip** _____

File or Claim # _____

Adjuster _____ **Telephone #** _____

Date of Injury _____ **Employer at Time of Injury** _____

Name and # of Attorney _____

Is Work Comp. Insurance: Paying Protesting Medical Bills

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MOTOR VEHICLE INSURANCE INFORMATION

Please fill out the bottom of this form if physical therapy is being paid by an auto insurance company

Insurance Company _____

Address _____

City _____ **State** _____ **Zip** _____

File or Claim # _____

Adjuster _____ **Telephone #** _____

Date of Auto Accident _____

Name of the Policy Holder _____

Relationship to the Policy Holder: Self Other party at fault

Name and # of Attorney _____