WELCOME TO
SPORT Clinic of Greater Milwaukee, Inc.

G E N E R A L

Patient Name: ______________________
(Legal Name)
Address: ______________________

City: ______________ State, Zip: __________

Home Phone: __________ Work Phone: __________

Cell: ______________ **Birthday:** __________

Sex: ü Male ü Female

Social Security #: ______________________

Marital Status: ü M ü S ü W ü D

Employer: ______________________ Retired: ü Yes

Occupation: ______________________

What made you choose SPORT Clinic?
ü Yellow Pages ü Previous patient ü Web site ü Doctor
ü Friend/Family ü Other ó explain ______________

Person to Notify in Case of Emergency?

Name: ______________ Phone: __________

Referred by: Dr. ______________________

Primary Physician: ______________________

Todayøs Visit is the Result of:

ü Motor Vehicle Accident

Do you want SPORT Clinic to bill auto insurance?
ü Yes ü No *(If yes, Please fill out info on back of form)*

ü Workersø Compensation Injury

Do you want SPORT clinic to bill Workersø Comp?
ü Yes ü No *(If yes, Please fill out info on back of form)*

ü Other Type of Accident (Please Explain)

____

What will we be treating today?
ü Knee ü Back ü Shoulder ü Neck ü Elbow ü Ankle/Foot
ü 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 #: ______________________

Subscriberøs Employer: ______________________

Relationship to Subscriber:

ü Self ü Spouse ü Child ü Other

Subscriberøs Birthdate: ______________________

Secondary Insurance Co.: ______________________

Subscriber Name: ______________________

Subscriber ID #: ______________________

Group ID #: ______________________

Subscriberøs Employer: ______________________

Relationship to Subscriber:

ü Self ü Spouse ü Child ü Other

Subscriberøs 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 email address:

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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 of Claim #: ____________________

Adjuster: ____________________ **Telephone #:** ____________________

Date of Injury: ____________________ **Employer at Time of Injury:** ____________________

Name and # of Attorney: ____________________

Is Work Comp. Insurance: ü **Paying** ü **Protesting Medical Bills**

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 of Claim #: ____________________

Adjuster: ____________________ **Telephone #:** ____________________

Date of Auto Accident: ____________________

Name of Policy Holder: ____________________

Relationship to the Policy Holder: ü **Self** ü **Other party at fault**

Name and # of Attorney: ____________________