SOAR – PATIENT DEMOGRAPHIC SHEET ACCT #:

Date:

My Appointment is with Dr.

PATIENT DEMOGRAPHIC WORKSHEET						
PATIENT	PATIENT NAME	MARITAL STATUS	DOB	SEX	AGE	SSN
	STREET ADDRESS	APT/SUITE#	CITY AND STATE		ZIP	
	WORK PHONE NUMBER #	HOME PHONE NUMBER #		MOBILE PHONE		
	EMPLOYER/SCHOOL NAME	OCCUPATION		EMAIL ADDRESS		
	EMPLOYER STREET ADDRESS	CITY AND STATE		ZIP CODE		
RESP PARTY	RESP PARTY NAME	OCCUPATION(INDICATE IF STUDENT)		HOME PHONE		
	RELATIONSHIP TO PATIENT	PATIENT TYPE		WORK PHONE		
	STREET ADDRESS	CITY AND STATE		ZIP CODE		

INSURANCE INFORMATION						
INSURANCE	(CIRCLE ONE) MEDICARE MEDICAID HMO PPO EPO POS PRIVATE NONE OTHER:_____					
	PRIMARY INSURANCE	EFFECTIVE DATE	ID /GROUP NUMBER			
	POLICY HOLDER NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
	SECONDARY INSURANCE	EFFECTIVE DATE	ID / GROUP NUMBER			
	POLICY HOLDER NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
	EMERGENCY CONTACT	RELATIONSHIP	PHONE #			

TYPE OF PAYMENT	
PAYMENT	COPAY AMOUNT $ (CIRCLE ONE) CHECK CASH VISA MASTERCARD DISCOVER AMEX
	DOES THIS PATIENT'S INSURANCE REQUIRE AN AUTHORIZATION OR REFERRAL NUMBER? (CIRCLE ONE) YES NO
	I UNDERSTAND THAT IF I DO NOT HAVE A VALID AUTHORIZATION FROM MY INSURANCE COMPANY TO COVER SERVICES PERFORMED, I WILL BE PERSONALLY RESPONSIBLE FOR THE CHARGES IN FULL, AND I AGREE TO PAY, IN FULL, ANY CO-PAYS, DEDUCTABLES, OR CO-INSURANCE AMOUNTS THAT MY INSURANCE COMPANY DEEMS MY RESPONSIBILITY, INCLUDING THOSE RESULTING FROM MY FAILURE TO OBTAIN THE NECESSARY REFERRALS AND/OR OTHER AUTHORIZATIONS FROM MY PRIMARY CARE AND/OR REFERRING PHYSICIAN WHEN REQUIRED. I AUTHORIZE A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
	SIGNED: _____ **DATE:** _____

SPORTS ORTHOPEDIC AND REHABILITATION MEDICINE ASSOCIATES

S·O·A·R
THE TEAM APPROACH
Sports, Orthopedic And Rehabilitation Medicine Associates

NAME: _____ **AGE:** _____ **DATE:** _____

SEX: ❒ M ❒ F **MARITAL STATUS:** ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOW

OCCUPATION: _____ **EMPLOYER:** _____

HOW DID YOU LEARN ABOUT THIS OFFICE? _____

CHIEF COMPLAINT AND DURATION OF SYMPTOMS: _____

HOW DID THIS ACCIDENT OR INJURY OCCUR? (i.e., football, skiing, auto accident, etc.)

WHERE? _____

WHEN? (date) _____

ANY PREVIOUS PHYSICAL THERAPY, SURGERIES OR X-RAYS? ❒ YES ❒ NO

IF YES, EXPLAIN _____

HISTORY OF:	Yes	No	If Yes, Explain		Yes	No	
Arthritis	❒	❒	_____	Hx of MRSA	❒	❒	_____
Diabetes Type	❒	❒	_____	Cancer	❒	❒	_____
Thyroid Disease	❒	❒	_____	Cigarette Usage	❒	❒	_____
Bleeding Disorders	❒	❒	_____				

Personal or family history of blood clots _____ ❒ ❒

_____

CURRENT MEDICATIONS:

ALLERGIES TO MEDICATIONS: _____

DO YOU PARTICIPATE IN ANY SPORTS'? _____

PRIMARY CARE PROVIDER: _____

SOAR Assignment of Benefits

I hereby assign to Sports Orthopedic and Rehabilitation (SOAR) all benefits related to my medical care including major medical services rendered by any physician or provider associated with SOAR. This assignment included benefits from Medicare, governmental insurance plans, PPO plans and any other private health insurance plans.

I understand that I am financially responsible for all charges for services and/or supplies received by me that are not covered, including those outlined within the terms of any managed care contracts including but not limited to co-pays, co-insurance, deductibles, non-covered services or out-of-network patient portions.

If my treatment is related to a verified, accepted and authorized Workers' Compensation injury, I understand that I am responsible for any charges for treatment that are unrelated to my Workers' Compensation injury and for all services if the injury is determined to be non-work related.

I certify that the information I have reported with regard to my insurance coverage is correct and authorize the release of any necessary information to my insurance company that is needed to determine any benefits to which I am entitled. I further understand that it is my responsibility to provide any changes to my insurance coverage that are necessary for billing. I will be responsible for all services if I fail to provide this accurate information.

This authorization will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

Relationship to Patient: _____

I, _____ authorize SOAR staff to discuss my medical services, including related billing and insurance issues, with _____.