

The Sports Medicine Institute of Indiana

PATIENT INFORMATION FORM

MR# _____
(Office use only)

Today's Date: _____

Patient's Name: _____		Maiden Name: _____	
(Last)	(First)	(M.I.)	
Social Security Number: _____		Date of Birth: _____	
Marital Status: _____		Male/Female: _____	Age: _____
Address: _____		(City)	(State) (Zip)
Email: _____			
Home Phone Number: _____		Work Number: _____	Cell Number: _____
Patient's Employer: _____		Occupation: _____	
Employer's Phone Number: _____		Address: _____	

Name of Spouse: _____	
Spouse's Employer: _____	Employer's Phone Number: _____

If patient is a minor, Parent/Guardian name(s): _____	
Phone Number: _____	Work Phone Number(s): _____

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance Co. Name: _____	Insurance Co. Name: _____
Policyholder's Name: _____	Policyholder's Name: _____
Policyholder's Date of Birth: _____	Policyholder's Date of Birth: _____
Policyholder's SSN: _____	Policyholder's SSN: _____
Relationship to Policyholder: _____	Relationship to Policyholder: _____
ID Number: _____	ID Number: _____
Group Number: _____	Group Number: _____
Effective Date: _____	Effective Date: _____
If Work Comp, has first report of injury been filed?	
YES NO Date of Injury: _____	

If you are new to our practice, how did you hear about us? (circle one)				
Primary Care Physician	Family/Friend	Yellow Pages	Insurance Company	Internet
Urgent Care Location	Doctor		Other	

Primary Care Physician: _____	Phone Number: _____
Address: _____	
(City)	(State) (Zip)
Referring Physician: _____	Phone Number: _____
(If different from primary care physician)	
Address: _____	
(City)	(State) (Zip)

Emergency Contact Name (not living with you): _____

Phone Number: _____ Relationship: _____