

# ALPINE SPORTS MEDICINE

## Patient Registration Patient Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital \_\_\_\_\_ Status: Weight: \_\_\_\_\_ Height \_\_\_\_\_  
Employer: \_\_\_\_\_ Social Security # \_\_\_\_\_  
E-mail : \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Spouse's Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Social Security: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

### Guarantor Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

### Insurance Information

**Primary Ins. Co:** \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Date of Birth : \_\_\_\_\_ Group # \_\_\_\_\_  
Ins. Co Address: \_\_\_\_\_ City /State/Zip: \_\_\_\_\_  
Ins. Co Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
**Secondary Ins. Co:** \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Group # \_\_\_\_\_  
Ins. Co Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Ins. Co Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Person To Call In Case Of Emergency

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Release of Benefits and Information: I authorize my Insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. Authorize the doctor or insurance company to release any information required for this claim.**

Signed : \_\_\_\_\_ Date : \_\_\_\_\_

