Name:
DOB:
Chart:
Age:
Date:

BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

## PATIENT DEMOGRAPHICS

Full Name: _____ Goes By: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Social Security: _____ Sex: (check) ☐ M ☐ F Marital Status: _____

Family Doctor: _____ Referring Physician: _____

Who is responsible for the bill (Name): _____ Address: _____

**(If patient is under 18)**

Relationship to Patient: _____ Phone: _____ Date of Birth: _____ Social Security #: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

## INSURANCE INFORMATION

**Primary Insurance**

Insurance Name: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Birth Date: _____ Employer: _____

**Secondary Insurance**

Insurance Name: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber Name: _____

Birth Date: _____ Employer: _____

## ADDITIONAL INFORMATION

Patient's Employment Status: ☐ Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Patient's Employer: _____ Occupation: _____ Employer Number: _____

Is the patient a Student Athlete: ☐ Y ☐ N If yes, what School: _____ Trainer: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Primary Language: _____ Hand Dominance: _____

Race: (Check): ☐ American Indian ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ White ☐ Unknown

Ethnicity: (Check): Hispanic or Latino Ethnicity Non-Hispanic or Non-Latino Ethnicity Unknown

How did you hear about us: ☐ Family/Friend ☐ Website ☐ Referring Physician ☐ Advertisement ☐ ER

**(Check all that apply)** ☐ Physician Presentation ☐ Trainer/School ☐ Previous Visit ☐ Social Media

## WORKERS COMPENSATION/3rd PARTY INSURANCE

Insurance Carrier: _____ Injury Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

Contact Person/Adjuster: _____ Claim #: _____