HOWARD HEAD SPORTS MEDICINE
REGISTRATION FORM

Today's Date	Physician

PATIENT INFORMATION

Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Sing / Mar / Div / Sep / Wid

Legal Name (if different from above)	Former Name	Birth Date / /	Age	Sex ❑ M ❑ F

Social Security #	Home Phone # ( )	Cell Phone # ( )

Mailing Address	City	State	Zip Code

Occupation	Employer	Employer Phone # ( )

Email Address	Reason for visit

Why did you choose HHSM as your provider?	❑ MD Referral	❑ Website	❑ Convenient Location	❑ Former / existing patient (please name)	❑ Other (please specify)

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone # ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation	Employer	Employer Address	Employer Phone # ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Insurance Claim Address / Phone #

Subscriber's Name	Subscriber's Social Security #	Birth Date / /	Group #	Policy #	Co-pay $

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Claim Address / Phone #

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Home Phone # ( )	Cell Phone # ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to HHSM. I understand that I am financially responsible for any balance. I also authorize HHSM or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*