CHARLOTTE SPORTS MEDICINE INSTITUTE, PA

Please complete all questions and present your insurance benefit card(s) .
Any co-pay will be collected prior to being seen.

PATIENT INFORMATION

DATE:_____

PATIENT NAME: (Last)_____(First)_____

(Middle)_____(Maiden)_____ Male □ Female □

STREET ADDRESS: _____

CITY/STATE/ZIP:_____

HOME PHONE:_____CELL #:_____WORK #:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

MARITAL STATUS: Married □ Single □ Legally Separated □ Divorced □ Widowed □

NAME OF SPOUSE (If no spouse, list a contact person or guardian)

(Name)_____ Daytime Phone #:_____

REASON FOR VISIT Personal Injury_____ Auto Accident_____ Workers Comp_____

Today's Problem:_____

Date of Onset:_____

Where/How did Injury Occur_____

INSURANCE INFORMATION Type of plan: PPO / HMO / POS Referral Needed? _____

Insurance Company: _____

Insured's Name:_____

Date of Birth:_____ Social Security Number:_____

Insured's Employer_____

Address_____

_____

Are you insured under an another medical health benefit plan? Yes_____ No_____

Other Insured's Name:_____ Date of Birth:_____

Employer_____

Group Name:_____ Policy Number:_____

Address:_____

If minor: Student: full-time_____ part-time_____ School Name:_____

Primary Care or Family Physician_____

Who referred you to our Clinic?_____ Phone No:_____

CHARLOTTE SPORTS MEDICINE INSTITUTE

MEDICAL HISTORY SHEET

PATIENT NAME:_____

DRUG ALLERGIES:

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS and DOSAGES:

_____

_____

_____

_____

_____

_____

ALLERGIC TO ADHESIVE TAPE? □ **Yes** □ **No** **WEIGHT:**_____ **HEIGHT:**_____

LIST MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

_____

LIST SURGERIES/ILLNESSES REQUIRING HOSPITALIZATION AND DATES:

_____

_____

_____

_____

_____

_____

ANY TYPE OF: □ **Heart Surgery** □ **Lung Surgery** □ **Heart Attack** □ **Problems with Anesthesia**

DO YOU FAINT AT THE SITE OF: □ **Blood** □ **Needles**

DO YOU USE NON-PRESCRIPTION DRUGS: □ **Yes** □ **No**

DO YOU SMOKE □ **Yes** □ **No** **HOW MUCH:** _____ **HOW MANY MONTHS/YEARS:**_____

DO YOU USE ALCOHOL: **Yes** **No** **HOW MUCH:**_____ **SOCIALLY?**_____

SIGNATURE: _____ **DATE:** _____