APPT ____________________ WITH ____________________________ ACCOUNT _______________

PATIENT INFORMATION: MR / MRS / MS ____

(LAST) (FIRST) (MIDDLE)

ADDRESS ____

(STREET) (CITY) (STATE) (ZIP)

SEX: M F AGE: _______ DOB: _________ MARITAL STATUS: M S W D

SS# _____________________ HOME PHONE: ( ) _______________ CELL: ( ) ______________

EMPLOYER: _______________________ PHONE: ( ) _______________ DOB ______________

SPOUSES NAME: ____________________________________ SS#: ____________________

EMPLOYER: ________________________________ PHONE: ( ) ____________ DOB __________

EMERGENCY CONTACT PERSON: ________________________________ PHONE: ( ) __________

WORK RELATED ☐ Yes ☐ No AUTO RELATED ☐ Yes ☐ No

* * * BILLING INFORMATION * * *

1st INSURANCE: _____________________________ POLICY HOLDER __________________________

2nd INSURANCE: _____________________________ POLICY HOLDER __________________________

3rd INSURANCE: _____________________________ POLICY HOLDER __________________________

* * * IF PATIENT IS UNDER 18 YEARS OF AGE * * *

CHILD LIVES WITH: MOTHER FATHER RELATIVE OTHER ________________

FATHER'S NAME: _____________________________ DOB ____________ SS# ________________

ADDRESS ____

EMPLOYER: ________________________________ PHONE: ( ) __________________________

MOTHER'S NAME: ____________________________ DOB ____________ SS# ________________

ADDRESS ____

EMPLOYER: ________________________________ PHONE: ( ) __________________________

LEGAL GUARDIAN IF OTHER THAN PARENT ________________________ PHONE: ( ) __________

I hereby authorize K Valley Orthopedics, P.C. / Southwestern Michigan Sportsmedicine Clinic to examine and treat me or my dependent child, and to perform such diagnostic tests and / or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my insurance claims and for any benefits payable under my policy (including Medicare) to be paid directly to K Valley Orthopedics, P.C. **I understand that I am personally responsible for all charges incurred that are not covered benefits as outlined by my insurance company. I understand that I am responsible for any deductible and co-payments.**

Date: ____________________ Signature: ____