Ty P. Affleck, MD www.srsportsmed.com

SANTA ROSA SPORTS MEDICINE

Patient Information

Welcome to Santa Rosa Sports Medicine. Please fill out the information below to help expedite your insurance processing.

Patient

First Name _____ Last Name _____

Street Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Date of Birth ___ /___ /___ SSN# _____ Sex: ☐ male ☐ female ☐ other

Driver's License # _____ Issuing State ___

Accident/First Symptom Date ___ /___ /___ Related to: ☐ employment ☐ accident ☐ sport ☐ other

Employer

Company Name _____

Street Address _____ City _____ State ____ Zip _____

Phone ( ) _____ Ext. ____ Email _____

Guarantor (PRIMARY INSURED IF DIFFERENT FROM PATIENT)

First Name _____ Last Name _____

Street Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Date of Birth ___ /___ /___ SSN# _____

Driver's License # _____ Issuing State _____

Emergency Contact

First Name _____ Last Name _____ Relationship _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

ASSIGNMENT AND RELEASE: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

Signed _____ Date ___ /___ /___

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