VCU Health

SPORTS MEDICINE

Athlete's **Legal** Name: _____ Male Female DOB: _____ RACE:_____
Home Address:_____
City: _____ State: _____ Zip: _____
Home Phone: _____ SSN: _____ Sport: _____

INSURANCE INFORMATION

Does your insurance require a referral from your PCP (primary care physician) to see another Dr. or Specialist? YES NO
If yes list: Primary Care Physician: _____ Phone Number: _____

Policy Holder's Information **(REQUIRED)**	Secondary (if applicable)
Legal Name: _____ Home Address: _____ _____ Home Phone ( ) _____ Work Phone ( ) _____ Insurance Co. _____ Policy Holder's ID #: _____ Policy Group #: _____ Claims Phone #: _____ Mailing Address for Claims: _____ _____ Policy holder's relationship to athlete: _____ _____ Is your dependent son / daughter covered under this policy? Yes No **Policy Holder's DOB:** _____ What type of insurance do you have? (circle) Traditional HMO PPO POS Other Does your insurance cover prescriptions? YES NO	Name: _____ Home Address: _____ _____ Home Phone ( ) _____ Work Phone ( ) _____ Insurance Co. _____ Policy Holder's ID #: _____ Policy Group #: _____ Claims Phone #: _____ Mailing Address for Claims: _____ _____ Policy holder's relationship to athlete: _____ _____ Is your dependent son / daughter covered under this policy? Yes No **Policy Holder's DOB:** _____ What type of insurance do you have? (circle) Traditional HMO PPO POS Other Does your insurance cover prescriptions? YES NO

	Emergency Contact	**Secondary Emergency Contact Person(s)**
Name(s)		
Address		
City St ZIP		
E-mail(s)		
Work/Cell #s		
Relationship to Athlete		

***** Please provide copy of front and back of insurance card**