

Account #: _____

Kearney Orthopedic & Sports Medicine

Please complete this form in full

Patient's Name _____ MI _____ Last Name _____

Address _____ Home Phone () _____

City _____ State _____ Zip _____ Cell Phone() _____

Birthdate _____ Age ____ Sex ____ Marital Status _____ Social Security # _____

Patient Employer _____ Work Phone () _____

Patient Employer Address _____ City/State _____ Zip _____

Spouse or Parent Name _____ Birthdate _____ Cell Phone() _____

Spouse or Parent S.S. # _____ Spouse or Parent Employer _____

Work Phone () _____ Spouse or Parent Employer City/State _____ Zip _____

Other Parent Name _____ Birthdate _____ Cell Phone() _____

Other Parent S.S. # _____ Other Parent Employer _____

Work Phone () _____ Other Parent Employer City/State _____ Zip _____

*******Please list a different contact than those listed above*******

Emergency contact _____ **Relationship** _____

Home Phone() _____ **Cell Phone()** _____

REFERRING DOCTOR _____ City/State _____

FAMILY DOCTOR _____ City/State _____

(We will send a report to the above Doctors after each visit unless otherwise instructed)

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Was this an accident or injury? _____ No _____ Yes Accident Date _____

If yes, please circle the type: workers' compensation motor vehicle sports liability other _____

What was injured: (knee, ankle, etc) _____

Please provide your insurance card(s) to the receptionist so we may make a copy

Primary Insurance Name: _____

Secondary Insurance Name: _____

Tertiary Insurance Name: _____

Patient Signature _____ **Date** _____

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THE POLICY IN OUR OFFICE IS THE PARENT WHO REQUESTS TREATMENT FOR THE MINOR IS RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED

AUTHORIZATION FOR CONSENT FOR MEDICAL TREATMENT: The above-named patient is either a minor patient under 19 years of age or an incapacitated adult and has a condition requiring diagnosis and treatment. As legal guardian, I hereby consent to such diagnostic procedures and treatment as are necessary in the judgement of the doctors of HealthServicesOne, P.C. or their assistants.

Legally responsible representative if patient is under 19 years old or an incapacitated adult

Relationship

Date

Witness