

# IMPACT SPORTS MEDICINE

## Patient Information:

\* We need a copy of your insurance card, credit card and driver's license.

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First Name	Middle Initial	Last Name
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Address

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City	State	Zip
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Home #	Work #	Cell #	Emergency #
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Social Security #	Birthday	Gender	Marital Status
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E-mail	Referred By
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Referring Physician	Injury Date	Injury Description
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Insured's Information:     Same as Patient     Work Comp?

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First Name	Middle Initial	Last Name
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Address

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City	State	Zip
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Home #	Work #	Cell #	Emergency #
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Social Security #	Birthday	Gender	Relationship to Pt.
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### For office use only:

Primary Insurance     Copy of card on file

Secondary Insurance     Not applicable     Copy of card on file

Drivers License     Copy on file

Card \_\_\_\_\_     Copy of card on file

# IMPACT SPORTS MEDICINE

**Workman's Compensation:**

Yes

No

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Employer Name

Employer Phone Number

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Address

City

State

Zip

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Insurance Name

Claim Number

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Adjuster's Name

Adjuster's Phone number

**Miscellaneous:**

Do you have an attorney involved in this case?

Yes

No

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Attorneys Name

Number

Address

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First doctor visit for this injury

Last date worked due to this injury

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Date Returned to work after this injury