# Sports Medicine
## Registration Form

**Name:**_____
Last Middle First

**Date of Birth**____/____/_____ Age:_____ SS#_____-____-_____ Male or Female

__Married __Widowed __Single __Separated__ Divorced __Minor

**Address**_____

_____
City State Zip

Home Phone:_____ Cell Phone:_____

Employer: _____Employer Phone:_____

**Emergency Contact**

Name: _____Relationship_____

Home Phone: _____Cell Phone:_____

**Parent/Guardian/Responsible Party**

Guardian Name: _____SS#_____

Address:_____
City State Zip

Home Phone: _____Cell Phone:_____

**Referring Doctor/Family Doctor**

Doctor Name:_____ Phone Number_____

**Insurance Information**

*Primary Insurance*:_____

*Secondary Insurance:* _____

**Authorization and Release**

-I authorize the release of any information including the diagnosis and the records of any treatment rendered to me or my dependent to third party payers and/or other health practitioners.

-I authorize you to transmit my medical records electronically/fax when necessary. I absolve Trinity Based Physicians and/or any professional providing services of any liability relating to the submission of these records.

-I authorize the release of information to Primary Care Physician.

-I authorize and request my insurance company to pay directly to Trinity Health System.

-I understand that my insurance carrier may pay less than the actual bill for services. Contractual adjustments with managed care contracts will be accepted, but I agree to be responsible for payment of all billable services rendered on my behalf or these charges.

-I understand that charges incurred for additional services (I.e, legal forms, letters to school/employer, insurance / disability forms, record releases) cannot be billed to my insurance and that I am financially responsible for these charges.

-I authorize that by signing this, I am consenting to treatment for myself or my dependent with a Trinity Based Physician and/or any professional providing services.

-I hereby give Trinity office personnel permission to leave a message on my answering machine concerning my appointment time or my dependent's appointment time.

**X**_____ _____
Signature Of Patient/Guardian Date