Trainor Sports Medicine

Patient Information

Today's Date

Patient Name

Date of Birth

Social Security #

Sex ◯ Male ◯ Female

Local Address
Street
Apt#
City, State, Zip

Permanent Address
Street
Apt#
City, State, Zip

Phone Home Number

Cell Home Number

Email Address

Employers Name

Employers Phone#

What is the reason for your visit today? (Feel free to be as detailed as you wish)

Is this do to an accident? ◯ Yes ◯ No If yes, date of the accident

If yes, is this a Work or Auto accident ◯ Work ◯ Auto ◯ Other

If Other, please explain

Primary Insurance

ID #

Secondary Insurance

ID#

Referred By

Your Medical Doctor

Incase of Emergency Contact:
Name
Telephone Number
Relationship

Patient Medical Information:
Please list any/all medical problems: (please feel free to be as detailed as you wish)

Operations you have had and dates:
(please feel free to be as detailed as you wish)

Please list any/all medications you are taking:

Do you have any allergies to any medication:

Do you smoke? ◯ No ◯ Yes If yes, how much?

Do you drink? ◯ No ◯ Yes If yes, how often?

How much on average?

If you have had any of the following conditions, please select each one that applies.

◯ Diabetes	◯ Kidney Disease	◯ High Cholesterol	◯ High Blood Pressure
◯ Arthritis	◯ Stomach Problems	◯ Stroke	◯ Stroke
◯ Intestinal Problems	◯ Asthima	◯ Heart Disease	◯ Gout
◯ Phlebitis (Blood Clots)	◯ Thyroid Problems	◯ Hepatitis	◯ Ulcers
◯ Hiatal Hernia	◯ Cancer	◯ H.I.V.	◯ Ulcers

Do you have any family history for any of the above mentioned conditions?

◯ No ◯ Yes If yes, please explain.

Woman Only: Are you pregnant? ◯ No ◯ Yes

PLEASE READ, PRINT OUT A COPY AND SIGN THE BELOW

In the event insurance is filed for services rendered to me, I hereby authorize this office to release information to my insurance company and assign benefits directly to Dr. Trainor and or Trainor Sports Medicine.

1. MEDICAL RECORDS RELEASE
I authorize the release of any medical information necessary to process a claim or any related claims for my physician, or to my attorney.

2. HMO AND MEDICARE PATIENTS - NON COVERED BENEFITS
I have been notified by my physician / supplier that Medicare/HMO is likely to deny payment for certain items (I.e. soft goods, outside x-ray review, ect.) If Medicare/HMO denies payment, I agree to be personally and fully responsible for payment.

3. SIGNATURE ON FILE / LIFETIME AUTHORIZATION
The signature below is required by ALL Medicare patients.
I request that payment of authorized Medical benefits be made to my physician / supplier for services rendered and any information needed to determine these benefits for for any related services.

Signature: _____

Date: _____

IN ORDER TO CONTROL BILLING COSTS, IT IS OUR POLICY THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

ACKNOWLEDGMENT OF RECEIPT

BY SIGNING THIS BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DR. JACK M. TRAINOR'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE/ NAME: _____

PLEASE PRINT NAME _____

SIGNATURE: DATE: _____

FOR OFFICE USE ONLY

DATE ACKNOWLEDGEMENT WAS RECEIVED: _____
OR
REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:

_____

_____

_____

_____

SIGNATURE: _____

NAME: _____

DATE: _____

Print Form