

Iberia Sports and Rehabilitation

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit ____ / ____ / ____
Referred By _____

Motor Vehicle Accident _____
That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____ Subscriber Name _____
ID _____ Max Benefit _____ Relationship _____
Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____ Subscriber Name _____
ID _____ Max Benefit _____ Relationship _____
Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

Tertiary Insurance

Insurance _____ Deductible _____ Subscriber Name _____
ID _____ Max Benefit _____ Relationship _____
Group # _____ CoPay _____ CoInsurance _____ Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____