The S.P.O.R.T. Institute Medical Group, Inc.

Dr. William J. Previte

NEW PATIENT DATA SHEET

(Please print and complete **all** information)

Name:_____ Telephone: (____) _____
(Last) (First)

Address:_____ Zip Code: _____

Male ❑ Female ❑ Birthdate: ____ / ____ / ____ Age: _____

SSN#:_____ - _____ - _____ Drivers License #:_____

Employer: _____ Telephone: (____) _____

Address:_____ Zip Code: _____

Referred by: _____

****

Date of Accident: _____ Body Part: _____

Primary Insurance:

Company: _____
Policy Number: _____
Group Number: _____
Co-Pay: $_____
Deductible: $_____

Secondary Insurance:
(if applicable)

Company: _____
Policy Number: _____
Group Number: _____
Co-Pay: $_____
Deductible: $_____

PLEASE PRESENT INSURANCE CARD AT TIME OF APPOINTMENT:

IN CASE OF EMERGENCY PLEASE NOTIFY:_____
Address: _____ Phone: (____) _____
Relationship to patient: _____

AS A CONSIDERATION TO OUR PATIENTS, WE WILL BILL YOUR INSURANCE PLAN FOR ALL SERVICES. HOWEVER, ALL CO-PAYMENT AMOUNTS, DEDUCTIBLES, AND PATIENT PORTIONS FOR ANY AND ALL TREATMENT PROVIDED, ARE ULTIMATELY THE SOLE RESPONSIBLLITY OF THE PATIENT. A STATEMENT WILL BE ISSUED AS A COURTESTY FOR ANY AMOUNTS OWED. BY SIGNING BELOW, PATIENT AGREES TO BE RESPONSIBLE FOR ALL MONIES NOT PAID BY THE INSURANCE COMPANY FOR ANY REASON. ALSO, IN THE EVENT THE INSURANCE COMPANY SENDS THE CHECK(S) TO THE PATIENT FOR DR. PREVITES SERVICES, IT IS AGREED THE CHECKS WILL BE FORWARDED TO THE OFFICE IN A TIMELY MANNER.

SIGNATURE: _____ DATE: _____

White copy – billing Canary copy – patient file