Name:
DOB:
Chart:
Age:
Date:

PATIENT INTAKE

Carolina Sports Medicine & Orthopaedic Specialists

Provider you are seeing today:

☐ **Dr. Messina** ☐ **Dr. Lippe** ☐ **Dr. Fortun**
☐ **Shawn Fitzgerald, PA-C** ☐ **Chris Lariviere, PA-C**

Patient's Name: Last _____ First _____ Middle Initial ____

Account: _____ Referred by: _____

☐ Male ☐ Female Age: _____ Birthdate: _____ Emergency Contact: _____

Social Security #: _____ Phone:(____) _____ Relation: _____

Address: _____ Are you employed? ☐ Yes ☐ No How long? _____

City/State/Zip: _____ Occupation: _____

Home Phone:(____) _____ ☐ Full Time ☐ Part Time

Work Phone:(____) _____ Employer: _____

Cell Phone: (____) _____ Employer Address: _____

Email: _____ City/State/Zip: _____

PORTAL AUTHORIZATION:

By providing your e-mail address, you are giving us permission to communicate with you via our portal. You will receive an e-mailed invitation to set up access. If you **do NOT** wish to participate, please check here ☐

Employer Phone: (____) _____

Patient's Driver's License #: _____ State: ____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Preferred Method of Contact: ☐ E-mail ☐ Mail

Spouse's Name: _____

☐ Cellular Phone ☐ Home Phone ☐ Work Phone

Spouse's Employer: _____

Preferred Language:

Are you a student? ☐ Yes ☐ No

☐ English ☐ Spanish ☐ Other *specify* _____

School: _____

RACE: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White ☐ Prefer not to answer

ETHNICITY: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Prefer not to answer

PRIMARY INSURANCE / WORKER'S COMP

Carrier Name: _____

Policy Holder's Name: _____

Policy Holder's Birth Date: _____

Patient's Relationship to Policy Holder: _____

☐ Self ☐ Dependent ☐ Spouse ☐ Child

☐ Other _____

SECONDARY INSURANCE

Carrier Name: _____

Policy Holder's Name: _____

Policy Holder's Birth Date: _____

Patient's Relationship to Policy Holder: _____

☐ Self ☐ Dependent ☐ Spouse ☐ Child

☐ Other _____

Please give your insurance cards to the receptionist so that a copy can be made for our records.

RESPONSIBLE PARTY (RP) INFORMATION:

RP Name: _____ RP Occupation: _____

Address: _____ Employer: _____

City/State/Zip: _____ Address: _____

Home Phone:(____) _____ City/State/Zip: _____

SS#: _____ Birth Date: _____ Work Phone:(____) _____

Name:
DOB:
Chart:
Age:
Date:

PATIENT INTAKE

Patient's Name: Last _____ First _____ Middle Initial ____ DOB _____

Side of body: ☐ **LEFT** ☐ **RIGHT**

CURRENT PROBLEM:

Describe your current problem: _____

When did this problem begin? _____ Date _____

Were X-Rays taken? ☐ Yes ☐ No If yes, where were they taken? _____

Did you bring these X-Rays today? ☐ Yes ☐ No Were you seen in the Emergency Room by our Doctor? ☐ Yes ☐ No

Have you previously been treated by a physician in this practice? ☐ Yes ☐ No If yes, approximately when? _____

Were you injured in an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other: _____

If accident related, describe how the injury occurred: _____

Do you have an attorney? ☐ Yes ☐ No If yes, Name: _____

Signature Authorizing Treatment: _____ Date _____

(Patient's Signature. If patient is a minor, legal guardian's signature)

INSURANCE ASSIGNMENT:

I, the undersigned, have insurance coverage and assign directly to Carolina Sports Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

Signature of Insured / Guardian: _____ Date _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Carolina Sports Medicine for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Carolina Sports Medicine agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date _____