



SPORTS PHYSICAL INTAKE FORM

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Social Security Number		Date of Birth		U.S. Military Service (<input checked="" type="checkbox"/> one): <input type="checkbox"/> None <input type="checkbox"/> Currently Serving <input type="checkbox"/> Discharged
Address		City		State
		Zip Code		County
Home Phone ()		Work Phone ()		Cell Phone ()
Email				
Marital Status (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		Primary Language Spoken: <input type="checkbox"/> Limited English		Patient's Relationship to Responsible Party (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent
Gender (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Female <input type="checkbox"/> Male				
Race (<input checked="" type="checkbox"/> one): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one Race <input type="checkbox"/> Choose Not To Disclose				
Ethnicity (<input checked="" type="checkbox"/> one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Choose Not To Disclose				
Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your annual income? <input type="checkbox"/> \$1-\$27,000 <input type="checkbox"/> \$27,001-\$33,000 <input type="checkbox"/> \$33,001-\$40,000 <input type="checkbox"/> \$40,001+ <input type="checkbox"/> No Income				
How many people (including you) does your income support? _____				
Which describes your housing situation? <input type="checkbox"/> Own/Rent <input type="checkbox"/> Public Housing <input type="checkbox"/> Homeless				
Emergency Contact			Phone ()	
			Relationship to Patient	
RESPONSIBLE PARTY INFORMATION (enter name of person FINANCIALLY responsible for your account)				
Last Name		First Name		Middle Initial
Mailing Address		City		State
		Zip Code		County
Home Phone ()		Work Phone ()		Cell Phone ()
		Date of Birth		Social Security Number
INSURANCE COMPANY – INCLUDING MEDICAID				
Primary Insurance		ID#		Group #
		Insurance Company Address		
Name of Insured		Date of Birth		Insured's Employer
Relationship to Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step Child Parent <input type="checkbox"/> Foster Child <input type="checkbox"/> Foster Parent				
Assignment and Release: <i>I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.</i>				
PARENT/GUARDIAN SIGNATURE: _____			DATE: _____	

Consent for Treatment

I hereby authorize PanCare Health, its facilities and treatment centers, its affiliated providers, dentists, dental hygienists, nurse practitioners, physician assistants, psychologists, social workers and other medical personnel to administer examinations and treatments as deemed medically necessary.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____