PLEASE PRINT CLEARLY

MRN# Today's Date: _____

Tabeguache Sports Medicine - Patient Information Sheet

Patient Name _____ DOB _____ Age _____ Gender M / F

Mailing Address _____ Social Security # _____

City, State, Zip _____ Home Phone # _____

E-Mail Address : _____ Cell Phone # _____

Employer_____ Contact you at work? Y / N Work Phone # _____

If patient is a minor, name of legal guardian_____ Relationship to patient _____

Responsible Party/Guarantor (if not patient): _____ DOB _____ Age _____

Household Members

Family Member Name	Social Security #	Date of Birth	Relationship to Patient	Gender
				M / F
				M / F
				M / F
				M / F
				M / F

Optional Info:

Race ☐ American Indian/Alaskan ☐ Asian ☐ Native Hawaiian/Islander ☐ Black/African American ☐ White ☐ **NO THANKS**

Ethnicity ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ **NO THANKS** **Preferred Language**: _____

Circle One:

Clinical Summary: Print or Decline **Reminder Communication:** Mail or Decline

In case of Emergency Notify:

Name: _____ Phone # _____ Relationship _____

AUTHORIZATION FOR MEDICAL TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to Tabeguache Sports Medicine office treatment, provisions of modalities and procedures, as indicated by the provider. I have reviewed and agree with all office policies including Patient Rights and Responsibilities.

PATIENT'S SIGNATURE _____ **Date:** _____

GUARDIAN'S SIGNATURE (if patient is under 18): _____

Legal Guardian/Health Care Proxy: If you answer yes to any of the questions below, please provide our office with appropriate supporting documentation

Do you have a Legal Guardian or Healthcare Power of Attorney? ☐ Yes ☐ No

If yes, whom? _____

Do you have a living will or advanced directives? ☐ Yes ☐ No

Do you have a DNR order? ☐ Yes ☐ No