

POST STREET ORTHOPAEDICS & SPORTS MEDICINE

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 (415) 776-7878 (tel) (415) 776-7878 (tel)
 (415) 923-1036 (fax) (415) 520-9615 (fax)

Confidential Intake Form

(To safeguard your information, please do not e-mail this form to us)

Contact Information

LAST NAME		FIRST NAME (ANY INITIALS; NAME YOU GO BY)		MR.	MS.	MRS.	DR.	OTHER/NONE
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADDRESS			HOME TELEPHONE		CELL NUMBER			
CITY/STATE/ZIP			WORK TELEPHONE		FAX NUMBER			
OCCUPATION			E-MAIL ADDRESS					
EMPLOYER			DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER			
EMPLOYER'S TELEPHONE NUMBER			FULL NAME OF SPOUSE OR DOMESTIC PARTNER					
EMPLOYER'S ADDRESS			SPOUSE OR DOMESTIC PARTNER'S CONTACT TELEPHONE NUMBER					
			SPOUSE OR DOMESTIC PARTNER'S WORK NUMBER					
OTHER EMERGENCY CONTACT PERSON			OTHER EMERGENCY CONTACT PERSON'S NUMBER					

Referral Information

REFERRED BY	PRIMARY PHYSICIAN
REFERRING PHYSICIAN'S ADDRESS	

Reason for Visit (and Related Information)

WHICH PART OF THE BODY DOES THIS CONCERN?		RIGHT SIDE	LEFT SIDE
		<input type="checkbox"/>	<input type="checkbox"/>
IS THIS AN ILLNESS?	IS THIS AN INJURY?	HOW LONG HAVE YOU HAD THIS ISSUE? (DATE OF ONSET OR INJURY)	
IF THIS IS AN INJURY, IT HAPPENED . . .			
AT WORK	AT HOME	DURING A SPORTS ACTIVITY	AS THE RESULT OF AN AUTOMOBILE ACCIDENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAME(S) AND CONTACT INFORMATION OF ANY OTHER DOCTOR(S) YOU HAVE SEEN FOR THIS			
ARE ANY RELATED RECORDS AVAILABLE?		X-RAYS	MRI
		<input type="checkbox"/>	<input type="checkbox"/>
		CT	EMG
		<input type="checkbox"/>	<input type="checkbox"/>
PURPOSE OF APPOINTMENT	CONSULTATION ONLY	CONSULTATION AND TREATMENT	SECOND OPINION
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insurance Information

—PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST—

NAME OF PRIMARY INSURANCE PROVIDER		ID NUMBER
NAME OF SUBSCRIBER		GROUP NUMBER
		EFFECTIVE DATE
YOUR RELATIONSHIP TO SUBSCRIBER		CONTACT TELEPHONE NUMBER FOR PRIMARY INSURANCE PROVIDER
SUBSCRIBER'S SOCIAL SECURITY NUMBER		SUBSCRIBER'S DATE OF BIRTH
NAME OF SECONDARY INSURANCE PROVIDER		ID NUMBER
NAME OF SUBSCRIBER		GROUP NUMBER
		EFFECTIVE DATE
YOUR RELATIONSHIP TO SUBSCRIBER		CONTACT TELEPHONE NUMBER FOR SECONDARY INSURANCE PROVIDER
SUBSCRIBER'S SOCIAL SECURITY NUMBER		SUBSCRIBER'S DATE OF BIRTH

I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Post Street Orthopaedics & Sports Medicine (PSOSM) for the services provided. This assignment shall remain in effect until I submit a written revocation to PSOSM. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the above information to secure payment. A copy of this assignment shall be as valid as the original.

Date: _____

Patient Acknowledgment: _____