WELCOME TO the CHICAGO CENTER FOR SPORTS MEDICINE & ORTHOPEDIC SURGERY!

NEW PATIENT FACE SHEET

Last Name:	First Name:	MI:
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	☐ Male ☐ Female	SSN: _____-____-_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow		Birthdate:
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Decline		
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline		

Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	E-Mail:	
Indicate which phone number you would like to designate as your primary contact: ☐ Home ☐ Cell			
By indicating phone numbers above, you are authorizing Chicago Sports Orthopedics to leave important voicemails as needed.			

PATIENT EMPLOYMENT	☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Unemployed ☐ Disability		
☐ Check here if N/A	Employer:	Position:	
Office Phone:	City:	State:	

PRIMARY CARE PHYSICIAN	Last Name:	First Name:
☐ Check here if N/A	Facility/Hospital:	Phone Number:

EMERGENCY CONTACT	Last Name:	First Name:
Home Phone:	Cell Phone:	Relationship to Patient:

INSURANCE INFORMATION

Are you the insurance policy holder? ☐ Yes ☐ No	**If you are the policy holder, please skip to the next section.**		
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Policy Holder Last Name:	First Name:		MI:
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow		DOB:
Address:	City:	State:	Zip:
E-Mail:	Home Phone:	Cell Phone:	

ADDITONAL COVERAGE

Do you have a secondary policy? ☐ Yes ☐ No
Is this a Workman's Compensation Injury, Motor Vehicle Accident or Personal Injury Claim? ☐ Yes ☐ No
Is this injury in any way related to participation in an organized sport? ☐ Yes ☐ No
If you have answered YES to any of the above questions, please see a CSO Staff Member so you may provide information on possible additional coverage.

I understand that I am financially responsible for all charges for services, including the balance remaining after payment of possible insurance benefits. I hereby assign, transfer, and set over to Chicago Center for Sports and Orthopedic Medicine all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with my insurance company. I authorize the release of any medical information necessary to process this claim. I also consent to the use and disclosure of protected health information by Chicago Center for Sports and Orthopedic Medicine for treatment, payment and health care operations, to any healthcare provider. I understand that if my account is placed with an outside collection agency, that I am responsible for any fees associated with this outside agency or any third party, including, but not limited to late fees, interest, and Attorney fees. I have read the HIPAA Privacy Act Notice and understand these are my privacy rights. **Any returned checks will have a $40.00 fee. I also understand there will be a $25.00 fee for missed appointments/no show and cancellations made within 24 hours of my scheduled appointment time.**

Patient/Guardian Signature _____ Date: _____