

UNIVERSITY SPORTS MEDICINE

Edward D. Field, M.D.
2401 Professional Drive, Oxford, MS 38655
662-234-0424
Fax: 662-234-0485

Referring Physician _____ Date _____

PATIENT INFORMATION

Patient's Name (first) _____ (middle) _____ (last) _____
Mailing Address _____ City _____ State _____ Zip _____
Physical Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Marital Status: married / single / divorced / widow
Employer _____ Employer Address _____
City _____ State _____ Zip _____ Wk Phone _____ How long Employed _____
Sex M / F Date of Birth _____ Age _____ Social Security # _____

Spouse's Name _____ Spouse's Employer _____
Spouse's Wk Phone _____ Spouse's Cell Phone _____

If patient is under the age of 18 or full time student please fill this out:

School Attending _____
Mother's Name _____ Mother's Employer _____ Mother's Wk # _____
Father's Name _____ Father's Employer _____ Father's Wk # _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name _____
Insured's Name _____ Relationship to Patient _____
Insured's Date of Birth _____ Phone # _____ Social Security # _____
Employer (if insured through employer) _____

Secondary Insurance

Insurance Company Name _____
Insured's Name _____ Relationship to Patient _____
Insured's Date of Birth _____ Phone # _____ Social Security # _____
Employer (if insured through employer) _____

ACCIDENT INFORMATION

Date of injury / Accident _____ Was your injury the result of a fall, liability or auto accident? Yes / No_ _____
Is this a workman's comp injury Yes / No _____

I hereby assign, transfer and set over to University Sports Medicine, Dr. Field, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and /or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization. It should be understood that your insurance policy is an agreement between you and your insurance company to pay for certain medical expenses. Your physician's bill is an agreement between you and your physician. You are responsible for the FULL payment on your account regardless of the status of your claim. We will be happy to file your insurance for you as a courtesy to you but you will be responsible for following up with your insurance to make sure the claims are paid timely.

Patient / Parent Signature

Date