

**SPORTS MEDICINE CENTER/NORTHWEST FOOT AND ANKLE CENTER
SPORTS MEDICINE CENTER DAY SURGERY**

LAWRENCE W SNOW MD MARK L LEWIS DPM PETRINA C LEWIS DPM

RENTON AUBURN

NAME: (LAST) _____ (FIRST) _____ (MI) _____

DATE OF BIRTH: _____ AGE: _____ SEX: MALE FEMALE SS#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: S M W D EMAIL ADDRESS: _____

PHONE #: _____ CELL #: _____

REFERRED BY: _____ PCP: _____

EMPLOYER: _____ WORK #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____
SS#: _____ DATE OF BIRTH: _____

IB WC AA 3RD PARTY INJURY OTHER
PRIMARY (SEE ATTACHED COPY OF CARD(S))

INSURANCE CO: _____ PHONE #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

ID #: _____ GROUP #: _____ SS#: _____

SECONDARY

INSURANCE CO: _____ PHONE #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

ID #: _____ GROUP #: _____ SS#: _____

INJURY INFORMATION

WORK RELATED INJURY: YES NO DATE OF INJURY: _____
AUTO ACCIDENT: YES NO BODY PART: R / L _____
3RD PARTY ACCIDENT: YES NO CAUSE: _____
OTHER INJURY: YES NO

WORKERS COMPENSATION OR 3RD PARTY INFORMATION

INSURANCE CO: _____ PHONE#: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ CLAIMS MNGR: _____

CLAIM #: _____ CLAIM OPEN: Y N CLAIM CLOSED: Y N IF YES DATE: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I AUTHORIZE NORTHWEST FOOT AND ANKLE CENTER, SPORTS MEDICINE CENTER, AND /OR SPORTS MEDICINE CENTER DAY SURGERY TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO NORTHWEST FOOT AND ANKLE CENTER, SPORTS MEDICINE CENTER, AND/OR SPORTS MEDICINE CENTER DAY SURGERY. I AUTHORIZE RELEASE OF INFORMATION NECESSARY TO COLLECT ANY PAYMENTS TO ALL MY INSURANCE COMPANIES. I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO ANY AND ALL PHYSICIANS INVOLVED IN MY CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF ITS ORIGINAL. I AUTHORIZE THE USE OF SIGNATURE ON FILE TO BE USED ON ALL OF MY INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF ANY PRECERTIFICATION, REFERRALS, OR CHANGES NEEDED FOR MY INSURANCE.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____