Komprehensive

Primary Care & Sports Medicine

Michael Ward M.D

Family Practice - Sports Medicine - Board Certified - Fellowship Trained

PATIENT INFORMATION

*Patient Name:*________________ *Date of Birth:*____________ *Age:*________

*Address:*________________ *City:*____________ *Male* ☐ *Female* ☐

State: ________________ *Zip:*____________

Status: Minor ☐ *Dependent* ☐ *Single* ☐ *Married* ☐ *Widow* ☐ *Divorce* ☐ *Separated* ☐

SS#: ____________ *Home Phone:* ____________ *Cell Phone:* ____________

Employer: ________________ *Work Phone #:* ________________

Employer Address: ________________ *Primary Care Physician:* ________________

Emergency Contact: ____________ *Phone #:*____________ *Relation:*____________

Check *all that apply*

May we leave test results on your: *Home answering machine / Cell phone voice mail / Emails*

May we leave test results with a specific family member: *Yes / No*

Name of family member ________________ *Relationship* ________________

Phone # if different ________________

INSUANCE/POLICY HOLDER INFORMATION WILL BE COPIED AND PUT IN FILE.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION.

I hereby authorize the physician at KOMPREHENSIVE PRIMARY CARE AND SPORTS MEDICINE, the nurses, and staff, under their direction, to conduct such examinations, administer treatment and medications, as they deem necessary or advisable. I hereby authorize the release of any information acquired by this facility during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier as required.

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Date *Patient's Signature*

Received a copy of the Notice

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Date *Patient's Signature*