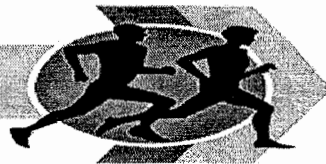


Komprehensive

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 _____

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

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION.

I hereby authorize the physician at KOMPRESHENSIVE 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.

Date Patient's Signature

Received a copy of the Notice

Date Patient's Signature