

Name: _____ Age: _____ Sex: _____ D/O/B: _____

SSN: _____

Employer: _____

Family Doctor: _____

Address: _____

Work Phone # _____

Referring Doctor: _____

Home Phone # _____

Primary Insurance: _____
Name of Subscriber: _____
Group: _____

Next of Kin: _____
Phone # _____
Relation: _____

Secondary Insurance: _____
Name of Subscriber: _____
Group: _____

Guarantor: _____
SSN: _____
Phone # _____
Employer: _____

Consent for Treatment:

I hereby consent and authorize the administration of all procedures/ tests/ treatments.

I hereby consent and authorize Marquette Orthopedic and Sports Therapy to furnish requested information from this visit to any healthcare providers named in this document involved directly or indirectly in my care and follow up.

I hereby and authorize Marquette Orthopedic and Sports Therapy to furnish requested information from third party insurers.

I acknowledge Marquette Orthopedic and Sports Therapy's Notice of Privacy Practices and may have a paper copy if requested.

I hereby assign insurance benefits to Marquette Orthopedic and Sports Therapy for Application.

Patient's (or legal representative's) Signature Date

Witness