



# DEMOGRAPHICS SHEET

## PATIENT INFORMATION (PLEASE PRINT)

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Sex (please circle):      M              F  
 Birth Date: (month/date/year) \_\_\_\_\_  
 Age: \_\_\_\_\_  
 SS #: \_\_\_\_\_

**Address:**  
 Street: \_\_\_\_\_  
 Apartment #: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Country (if not USA) \_\_\_\_\_  
 Home #: \_\_\_\_\_  
 Work #: \_\_\_\_\_  
 Cell #: \_\_\_\_\_

**Mailing Address (if different then the above):**  
 Street: \_\_\_\_\_  
 Apartment #: \_\_\_\_\_  
 P.O. Box: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Country (if not USA): \_\_\_\_\_

## EMERGENCY CONTACT (PLEASE PRINT)

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Home #: \_\_\_\_\_  
 Work #: \_\_\_\_\_  
 Cell #: \_\_\_\_\_

## PARENT or LEGAL GUARDIAN (PLEASE PRINT)

First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Home #: \_\_\_\_\_                      Work #: \_\_\_\_\_  
 Cell #: \_\_\_\_\_

## EMPLOYER (PLEASE PRINT)

Employer Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 Suite: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Country (if not USA) \_\_\_\_\_  
 Occupation: \_\_\_\_\_

## INSURANCE INFORMATION (PLEASE PRINT)

**Party Responsible for Bill:**  
 First Name: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_  
 Insured DOB: \_\_\_\_\_  
 Insured SS #: \_\_\_\_\_  
 Contract #: \_\_\_\_\_  
 Group #: \_\_\_\_\_

## MEDICAL INFORMATION (PLEASE PRINT)

**Is condition related to:**  
 Illness                                       Work/Employment  
 Auto Accident                               Other

Date of Injury: \_\_\_\_\_  
 Present Complaint: \_\_\_\_\_  
 List Daily Medications In Use: \_\_\_\_\_  
 \_\_\_\_\_  
 List Any Drug Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever had ULCERS:    Yes              No  
 If Female, are you pregnant?    Yes              No

Known Medical Problems: \_\_\_\_\_  
 \_\_\_\_\_  
 Family Physician: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

I hereby assign directly to Atlanta Center for Athletes all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether or not paid by insurance. Patient or responsible party agrees to pay any and all costs of collection and/or attorney fees required to settle account. I authorize the use of this signature on all my insurance submissions. I hereby authorize the release of all information necessary to secure the payment of benefits. In order to insure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to a designated referral provider and/or physician.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date