OrthoSports Associates, L.L.C.

Have you seen our doctors in the past?

___ Yes ___ No

Date _____ When?_____

Patient Information Sheet

PATIENT INFORMATION (PLEASE PRINT)

NAME	SEX	MARITAL STATUS	SOCIAL SECURITY NO.	AGE	BIRTHDATE

ADDRESS	CITY	STATE	ZIP	HOME PHONE NO.

EMPLOYER/SCHOOL AND ADDRESS	CITY,STATE, ZIP	OCCUPATION & YEARS EMPLOYE	BUSINESS PHONE

SPOUSE'S NAME	ADDRESS IF DIFFERENT FROM ABOVE

SPOUSE'S BIRTHDATE & S.S.#	SPOUSE'S EMPLOYER & PHONE	OCCUPATION

CONTACT OUTSIDE OF HOME & RELATIONSHIP	ADDRESS	CITY	STATE	CONTACT PHONE

PHYSICIAN OR OTHER INDIVIDUAL REFERRING YOU TO US

NAME	PHONE	CITY	STATE

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

FATHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE

FATHER'S BIRTHDATE & S.S. #	FATHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

MOTHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE

MOTHERS BIRTHDATE & S.S. #	MOTHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

RESPONSIBLE PARTY AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT	RELATION TO PATIENT	ADDRESS	CITY	STATE/ZIP	HOME PHONE

1. INSURANCE-CO NAME & ADDRESS	GROUP/POLICY #	EFFECTIVE DATE

POLICY HOLDER/SUBSCRIBER NAME & ADDRESS	BIRTHDATE	SOC. SEC. #	RELATIONSHIP TO PATIENT

2. INSURANCE-CO NAME & ADDRESS	GROUP/POLICY #	EFFECTIVE DATE

POLICY HOLDER/SUBSCRIBER NAME & ADDRESS	BIRTHDATE	SOC. SEC. #	RELATIONSHIP TO PATIENT

ACCIDENT OR REASON FOR VISIT INFORMATION	WERE YOU INJURED ON THE JOB? _____YES _____ NO	WAS AN AUTOMOBILE INVOLVED? _____ YES _____ NO	DATE OF INJURY? _____

ATTORNEY CONTACTED? _____ YES _____ NO	WERE XRAYS TAKEN OF INJURY/PROBLEM?	WHERE?	DATE XRAYS TAKEN _____

HOW AND WHERE WAS INJURY SUSTAINED?

WHAT INJURIES WERE SUSTAINED?

I HEREBY ASSIGN TO AND AUTHORIZE PAYMENT TO ORTHOSPORTS ASSOCIATES, LLC. TO REALEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT TO ANY INSUROR, GOVERNMENT AGENCY PROVIDING BENEFITS, OR TO ANYONE FOR CHARGES.

X SIGNED _____

I HEREBY ASSIGN TO AND AUTHORIZE PAYMENT DIRECTLY TO ORTHOSPORTS ASSOCIATES, LLC. OF ALL BENEFITS PAYABLE UNDER THE TERMS OF ANY APPLICABLE INSURANCE POLICY. I REALIZE THE INSURANCE, WORKMEN'S COMPENSATION, AND/OR LIABILITY INSURANCE MAY NOT PAY THE ENTIRE BILL. I AGREE TO PAY THE DIFFERENCE OF THE ENTIRE BILL IF NECESSARY. FURTHER, I FULLY UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES ASSOCIATED WITH MY ACCOUNT. IF MY ACCOUNT IS NOT PAID IN FULL WHEN DUE, AND THE PRACTICE SHOULD RETAIN AN ATTORNEY OR COLLECTION AGENCY, I AM RESPONSIBLE TO PAY, IN ADDITION TO ALL CHARGES ASSOCIATED WITH MY ACCOUNT: (1) ANY COLLECTION AGENCY FEE, WHICH WILL NOT EXCEED FORTY PERCENT (40%) OF THE DEBT, PLUS (2) ALL COSTS AND EXPENSES (INCLUDING, BUT NOT LIMITED TO, ATTORNEY'S FEES, COURT COSTS AND COURT RELATED EXPENSES) INCURRED IN CONNECTION WITH EFFORTS TO COLLECT THE DEBT. I HEREBY WAIVE MY EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA.

X SIGNED _____

NOTICE OF NONDISCRIMINATION: OrthoSports Associates, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OrthoSports Associates, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.