EMORY
SPORTS MEDICINE
CENTER

New Patient Information Form

Patient's **LEGAL** Name: _____ DOB: _____

Address/City/Zip: _____

Phone Number: _____ SSN/DL # (must have if 18 or older) _____

Mother's Maiden Name (required if under 18): _____

Email Address: _____

**Insurance Name/type: _____ PPO, POS, HMO, Choice Plus, Open Access

Subscriber/Member ID: _____ Group #: _____

Policy Holder's Name: _____

What is the injury/diagnosis, including right or left: _____

_____

Will you bring x-rays, MRI, etc.? _____ What sport/position? _____

What school/organization is the athlete from? _____

Preferred appointment day/time/MD: _____

IF THE PATIENT IS "17 OR YOUNGER" WE MUST HAVE THE FOLLOWING

Parent/Guardian **LEGAL** Name: _____

DOB: _____ SSN or DL # (required) _____

Address/Phone if different from patient: _____

_____

*this form may be emailed to your athletic trainer

**Please include a copy of insurance card if at all possible