



PENSACOLA ORTHOPAEDICS & SPORTS MEDICINE
 5147 North 9th Avenue, Suite 322
 Pensacola, FL 32504

PATIENT INFORMATION

R. Barry Lurate, M.D.
Mark T. Caylor, M.D.

REFERRED BY										
PATIENT'S NAME (PLEASE PRINT)				MARITAL STATUS		SEX				
				S	M	W	D	Sep	M	F
DATE OF BIRTH		AGE		SS#						
STREET ADDRESS		PERMANENT		TEMPORARY		CITY AND STATE			ZIP CODE	
HOME PHONE #										
PATIENT'S EMPLOYER / SCHOOL						OCCUPATION (INDICATE IF STUDENT)				
EMPLOYER'S STREET ADDRESS						BUSINESS PHONE #			EXT.	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES

SPOUSE (Or if under 18 - name of guarantor)		STREET ADDRESS / CITY / STATE		ZIP CODE		HOME PHONE #	
EMPLOYER		EMPLOYER ADDRESS			WORK #		
SS#		DATE OF BIRTH		RELATIONSHIP TO PATIENT			
POLICY HOLDER		RELATIONSHIP TO PATIENT		POLICY HOLDER DATE OF BIRTH			
POLICY HOLDER ADDRESS (Street / City / State)				POLICY HOLDER HOME #		POLICY HOLDER WORK #	
POLICY HOLDER EMPLOYER				POLICY HOLDER SS #			
WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF INJURY		IF YES, PHONE NUMBER TO CALL FOR TREATMENT AUTHORIZATION. (EMPLOYER OR INSURANCE CARRIER)			
WERE YOU IN OR AROUND A VEHICLE/AUTOMOBILE WHEN THE INJURY OCCURRED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHERE WERE X-RAYS TAKEN. (Name of Facility)			DATE X-RAYS TAKEN		
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.							

NEAREST RELATIVE NOT LIVING WITH YOU

NAME		RELATIONSHIP TO PATIENT			
ADDRESS		STREET / P.O. BOX		HOME PHONE NUMBER ()	
CITY		STATE		ZIP CODE	
				WORK PHONE NUMBER ()	

PLEASE READ AND SIGN

I hereby authorize Pensacola Orthopaedics & Sports Medicine to release any information acquired in the course of my examination or treatment.
 I hereby authorize payment directly to Pensacola Orthopaedics & Sports Medicine of the amount due me in my pending claim for medical expenses payable under the terms of my insurance.
 I agree that any balance not covered will be paid by me and that photocopies of this form will be as valid as the original.
 I also authorize any physician, hospital, or clinic to provide full details of my medical history and treatment to Pensacola Orthopaedics & Sports Medicine.

Date _____ X _____
 PATIENT OR RESPONSIBLE PARTY SIGNATURE