Sanford Sports Physical Patient Registration Form

*All Fields Required

Date: _____

PATIENT INFORMATION:			
Patient's Full Legal Name:	Preferred Name:	DOB:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

EMERGENCY CONTACT INFORMATION:			
Name:	Relationship to Patient:	Address:	Phone: Home or Cell (Circle One)

GUARANTOR INFORMATION (Who should receive the Sanford Statement):			
Name:	DOB:	Relationship to Patient:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

Insurance will be filed for Vaccines ONLY **PRIMARY INSURANCE COVERAGE:**			
Insurance Name, Address and Phone Number:	Group Number:	ID Number:	
Subscriber Name:	DOB:	Relationship to Guarantor:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

SECONDARY INSURANCE COVERAGE (IF APPLICABLE):			
Insurance Name, Address and Phone Number:	Group Number:	ID Number:	
Subscriber Name:	Subscriber DOB:	Relationship to Guarantor:	Sex:
Home Address:		Phone: Home or Cell (Circle One)	

Office Use ONLY:
Prepayment Received? ☐ YES ☐ NO

- If yes, how will the $50 prepay made?

  ☐CASH ☐CHECK ☐CREDIT CARD (Will be collected over the phone prior to service)