FOUNDRY ORTHOPEDICS
FOUNDRY SPORTS MEDICINE AND FITNESS

285 Promenade Street
Providence, RI 02908
Telephone: (401)459-4001
Fax: (401)459-4010

Date:____________________

Patient's Last Name:_____________________________First___________________MI____Phone:_________________
Cell Phone:___________________

Address:____City:________________State:_______Zip:______

Age:______Date of Birth:_____________Social Security:________________________ (circle one): MALE FEMALE

Name of Primary Care Physician:______________________ Referring Physician:___________________________________

Pharmacy Preference (Include Location)____

Retired: Y N Marital Status: MARRIED SINGLE DIVORCED WIDOWED

Employer ______________________ Address:____________________ City:_____________ State:____ Phone:____________

Primary Insurance Name:____ ID#____________________

Insured Card Holder's Name: _________________________________Date of Birth:__________________________

Secondary Insurance Name:____ID#____________________

Insured Card Holder's Name: _________________________________Date of Birth:________________________

CHIEF COMPLAINT (reason for visit): ____

Injury Related to Auto Accident? YES _____ NO _____ State Accident Occurred? ____________________

Injury Related to Employment? YES _____ NO _____ Is this a liability Injury? YES _____ NO _____

If Liability, Attorney Name: ____Phone#:______________________

Emergency Contact Name:____ Phone#:______________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: My physician/ physical therapist is authorized to provide to my referring physician, insurance company or their representatives, or my attorney information they may require regarding my condition while under their treatment or observation, including but not limited to history obtained, medical history, physical findings, diagnosis, prognosis and treatment recommended.

FINANCIAL AGREEMENT: In consideration of the services rendered by my physician/ physical therapist at my request and direction, I understand I am responsible for, and agree to pay in full all charges incurred for services rendered. I further understand that in the event that special arrangement have been made to have payment made through my insurance company, and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawful and reasonable interest charges after thirty (30) days from date of billing on any unpaid balance.

____ ____
SIGNATURE OF PATIENT DATE WITNESS TO PATIENT SIGNATURE DATE

____ ____
SIGNATURE OF PARENT OR GUARDIAN DATE WITNESS TO PARENT OR GUARDIAN DATE