SELINA SHAH
Dance & Sports Medicine

BASS
MEDICAL GROUP

Today's Date: _____ **Referring Physician:** _____ **Primary Care Physician:** _____

PATIENT DEMOGRAPHICS

Patient's Legal Name: (Last, First, Initial)	**Preferred Name**:	**SSN:**
		Driver's License #
Home Address:	**City & State**:	**Zip**:
Date of Birth	**Gender** ☐M ☐F	**Marital Status**: ☐Single ☐Mar ☐Div ☐Sep ☐Wid
Email:		
Best Contact Number: ☐Cell ☐Home ☐Work	Other Contact Number: ☐Cell ☐Home ☐Work	Other Contact Number: ☐Cell ☐Home ☐Work
Employer:	**Occupation**:	**Work Phone#:**
Primary Care Physician:	**Employment Status**: ☐Full-Time ☐Part-Time ☐Retired ☐Not Working	
How were you referred to our office? (Physician, family member, friend, insurance, internet source etc. - Please list name/details) :		

IF PATIENT IS A MINOR PLEASE COMPLETE: **Are Parents Married?** ☐ **Divorced?** ☐	PARENT: (Name/Relation)	Work#:	Cell#:
	PARENT: (Name/Relation)	Work#:	Cell#:

RESPONSIBLE PARTY/GUARANTOR (IF DIFFERENT FROM ABOVE OR THE PATIENT IS A MINOR)

Name:	Relationship:	Date of Birth:
Address:	City & State:	Zip:

INSURANCE INFORMATION

Name of **Primary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other		
Name of **Secondary** Insurance Carrier:		
Subscriber Name:	Subscriber SSN:	Subscriber DOB:
ID#:	Group#:	
Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other		

Is this a work related injury? ☐No ☐Yes If Yes, list date of injury: _____

IN CASE OF EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone:	Cell/Work phone :

GENERAL INFORMATION

Interpreter needed? ☐Yes ☐No	Preferred Language:
Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline	Race: ☐American Indian/Alaska Native ☐Black/African American ☐Hawaiian/Pacific Islander ☐White/Caucasian ☐Other_____ ☐Decline
Religion:	