

## Patient Information Sheet

**OFFICE USE ONLY:**  
 Delivery Person Name: \_\_\_\_\_

**PATIENT INFORMATION:**  
 Name: Last \_\_\_\_\_ First \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) Male  Female   
(for Patient identification purposes only)

**INSURED'S INFORMATION:**  
 Name: Last \_\_\_\_\_ First \_\_\_\_\_  
 Relationship to Patient:  Spouse  Parent  Other \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year) (for Patient identification purposes only)

**PRIMARY INSURANCE:**  
 Insurance Company Name: \_\_\_\_\_  
 Identification Number: \_\_\_\_\_ Employer/Group Number: \_\_\_\_\_  
 Claim Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Claims Mailing Address: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_  
 Health  Work Comp  Auto  Other: \_\_\_\_\_  
**If carrier is Blue Cross, Blue Cross/Blue Shield, Anthem Blue Cross, or an affiliate of Blue Cross, INSURED MUST SEND EXPLANATION OF BENEFITS (EOB)/DENIAL/PAYMENT TO GAME READY to enable Game Ready to bill your secondary insurance.**

**SECONDARY INSURANCE:**  
 Insurance Company Name: \_\_\_\_\_  
 Identification Number: \_\_\_\_\_ Employer/Group Number: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Health  Work Comp  Auto  Other: \_\_\_\_\_

**DIAGNOSIS AND RELATED INFO:**  
 Diagnosis: \_\_\_\_\_  
 ICD9: \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Physician UPIN: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_