PANCARE OF FLORIDA, INC.

SPORTS PHYSICAL INTAKE FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** | **U.S. Military Service (☑ one):** ☐ None ☐ Currently Serving ☐ Discharged

Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Email**

Gender (☑ one): ☐ Female ☐ Male

Primary Language Spoken: ☐ Limited English

Patient's Relationship to Responsible Party (☑ one): ☐ Self ☐ Spouse ☐ Natural Child ☐ Parent ☐ Foster Child ☐ Foster Parent

Race (☑ one): ☐ American Indian/Alaska Native ☐ Asian Indian ☐ Other Asian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ More Than One Race ☐ Choose Not To Disclose

Ethnicity (☑ one): ☐ Chicano/Chicana ☐ Cuban ☐ Hispanic ☐ Latino/Latina ☐ Spanish ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Non-Hispanic/Latino/Latina/Spanish ☐ More Than One Ethnicity ☐ Choose Not To Disclose

Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? ☐ Yes ☐ No

What is your annual income? ☐ $0-$15,060 ☐ $15,061-$18,825 ☐ $18,826-$22,590 ☐ $22,591-$26,355 ☐ $26,356-$30,120 ☐ $30,121 & UP

Number of people in household:_____

Emergency Contact	**Phone** ( )	**Relationship to Patient**

RESPONSIBLE PARTY INFORMATION (enter name of person *FINANCIALLY* responsible for your account)

Last Name | **First Name** | **Middle Initial**

Mailing Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Date of Birth**	**Social Security Number**

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Assignment and Release: *I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.*

PARENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

Consent for Treatment

I hereby authorize PanCare Health, its facilities and treatment centers, its affiliated providers, dentists, dental hygienists, nurse practitioners, physician assistants, psychologists, social workers, and other medical personnel to administer examinations and treatments as deemed medically necessary.

Parent/Guardian Signature:_____ Date:_____