

Collier Sports Medicine and Orthopaedic Center  
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11181 Health Park Blvd, Suite 2220  
Naples, FL 34110

Welcome to our Practice Please fill out completely

Patient Information

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_  
Out-of-Town Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Months you are in Florida if not year round: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Employers Address: \_\_\_\_\_

Medical Information

Reason for visit: \_\_\_\_\_ Allergies to drugs: \_\_\_\_\_  
Medications: \_\_\_\_\_  
Medical History! Major or Chronic Illnesses (Diabetes/High Blood Pressure): \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_ Family Doctor: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Payment Responsibility

Person responsible for payment: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Soc. Sec. #: - - Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Responsible party employed by: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Work Address:

*\*please have your insurance cards ready to be copied\**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_  
Has your deductible been met? \_\_\_\_\_ How much is your deductible? \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Work related injury? Yes / No Auto related injury? Yes / No If yes, give date and place: \_\_\_\_\_  
Liability case? Yes / No Attorney's name: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_  
Attorneys Address: \_\_\_\_\_  
How do you wish to pay? Check / Cash / Credit Card #: \_\_\_\_\_ Exp Date \_\_\_\_\_

I give permission to administer treatment and perform tests as determined necessary by the Physician in the diagnosis and treatment of my condition. Furthermore, I give permission to release information relating to my medical treatment to my insurance company in order to process my claim services. I understand that I am responsible for all bills associated with this office and all tests, treatments.

x-rays etc. that are not covered by my insurance. I further understand that it is my responsibility to get preauthorization from my insurance carrier for tests and/or treatment (i.e., MRI, physical therapy etc.) ordered by the Physician at outside facilities and to find out if the facility is a preferred provider. If am unable to keep an appointment. I need to give notice twenty-four hours in advance or a missed appointment fee may be charged. Your signature below signifies your understanding of this policy.

Patient/Guarantor Signature: \_\_\_\_\_

Date: \_\_\_\_\_