



Brad Rodgers, MD

Family Practice and Sports Medicine

Patient Information Form

First Name: Last Name: Sex: M/ F
Date of Birth: Social Security Number:
Mailing Address:
City: State: Zip Code:
Home Phone Number: Cell:
E-Mail: (may we contact you via e-mail) Yes/ No

Employer Name:
Employer Address:
Work Phone Number:

Pharmacy Name: Pharmacy Phone:
Pharmacy Address:
Medication Allergies:

Primary Insurance: Policy Number:
Subscriber Name: DOB: Phone:
Address: City: State: ZIP:

Secondary Insurance: Policy Number:
Subscriber's Name: DOB: Phone:
Address: City: State: ZIP:

Is this Work related: Yes / No (if yes, please fill out work comp form)

I authorize the release of any medical information necessary to process my claim and request payment directly to Brad Rodgers, MD Family Practice & Sports Medicine, LLC. This will also serve as authorization for this office to provide insurance information regarding any claim submitted on my behalf. I authorize payment of benefits to Brad Rodgers, MD Family Practice & Sports Medicine, LLC. I understand that I am responsible for all charges incurred for services rendered by Brad Rodgers, MD Family Practice & Sports Medicine, LLC.

Consent to obtain external prescription history

I authorize the physician to view my external prescription history via RX Hub Service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable to my providers and staff and may include prescriptions back several years.

Printed name of Patient or Patient's Representative

Signature of Patient or Patient's Representative

Date