SMART SPORTS Medicine Center

5307 Yellowstone Rd
Cheyenne, WY 82009

Phone: 307-632-7677
Fax: 307-778-8292

Patient Information

Last Name: _____ First Name: _____ Initial: _____

Address: _____City: _____ State: _____ Zip Code: _____

SSN: _____ Date of Birth: _____ Gender: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer (if minor parent/guardian employer information) : _____

Address: _____ Phone: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact

Last Name: _____ First Name: _____

Relationship: _____ Phone # _____

Type of Visit

_____ Insurance (Please present card at check in) _____ Self Pay (Payment due at time of service)

_____ Auto Accident (WE CAN NOT file third party) Date of accident: _____

_____ Worker's Compensation (We can only file State of Wyoming Work Comp) #_____

Case Manager: _____ Phone: _____ Date of Injury: _____

Referring Physician: _____ Phone: _____

Responsible Party ☐ Self

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship: _____ Phone #: _____

Insurance Information

Primary Insurance: _____ Member ID: _____ Group ID: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Primary Insurance Address: _____

Secondary Insurance: _____ Member ID: _____ Group ID: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance Address: _____