The Children's Hospital

SPORTS MEDICINE
for Young Athletes

Athlete Registration Form

Athlete Information

Date: _____ Sport: _____ School: _____

Injury: _____ Language: _____

Name: _____ Date of birth: _____

SS#: _____ Race: _____ Home phone: _____

Home address: _____

Primary Care Physician: _____ Phone: _____

Parent/Emergency Contact Information

Name: _____ Relationship to athlete: _____

Address: _____

Home phone: _____ Work/Cell phone: _____

Primary Insurance Information

Insurance Name: _____ Plan type: HMO PPO POS IND

Insurance Co. Address: _____

Insurance Co. Phone: _____ Subscriber name: _____

Subscriber Employer: _____ Subscriber SS#: _____

Subscriber date of birth: _____ Effective date: _____

ID#: _____ Group #: _____

Secondary Insurance Information

Insurance Name: _____ Plan type: HMO PPO POS IND

Insurance Co. Address: _____

Insurance Co. Phone: _____ Subscriber name: _____

Subscriber Employer: _____ Subscriber SS#: _____

Subscriber date of birth: _____ Effective date: _____

ID#: _____ Group #: _____

www.thechildrenshospital.org/sportsmedicine
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