
(Please Print)

## PLAYER REGISTRATION FORM

| | | | | | |
|---|---|---|---|---|---|
| Player's last name: First: Middle: | | | | | |
| Grade: | High School/Middle School Name and Coach Information: | | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: | | | Home phone no.: ( ) | | |
| P.O. box: | City: | State: | ZIP Code: | | |
| | E-Mail Address: | | | | |
| Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. | | ❑ Insurance Plan | ❑ Hospital | | |
| ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other | | | | | |
| Other family members seen here: | | | | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| | | | |
|---|---|---|---|
| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
| Is this person a patient here? ❑ Yes ❑ No | | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | |
| Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] | | | |
| ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other | | | |

| | | | | | |
|---|---|---|---|---|---|
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other | | | | | |
| Name of secondary insurance (if applicable): | Subscriber's name: | | Group no.: | Policy no.: | |
| Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other | | | | | |

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.:<br>(  ) | Work phone no.:<br>(  ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Juice All-Stars NC or insurance company to release any information required to process my claims.<br><br>*Patient/Guardian signature*  *Date* | | | |

Thank you,

**Head Coach/Director:**
James Black, BrickSquad Monopoly Grassroots Basketball NC
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