PATIENT INFORMATION FORM- PLEASE PRINT ALL INFORMATION CLEARLY

Please fill out this form completely so we can submit claims to your insurance carrier.

Last Name_____________________________First______________________M______Male/Female_______

Address____City__________________________

State_______Zip Code____________________Phone #__________________________Marital Status_________

Date of Birth_______________________ Age__________ Social Security #____________________________

Emergency Contact Name:_______________________**Emergency Contact Phone #**:___________________________

Do you have legal representation? Yes___________ No___________

If yes: Attorney name:_______________________________________Phone#____________________________________

Your Employer_______________________________________Phone#__________________________

Address____

Occupation______________________________

CHIEF COMPLAINT____

Is your visit today related to: **Workers compensation?** _______Yes ________No Date of Injury:______________

Auto accident or personal injury? ________Yes _________No Date of Injury:_____________________

IF YOU ARE NOT THE POLICYHOLDER ON THE INSURANCE, PLEASE COMPLETE THE FOLLOWING SECTION. IF THIS IS NOT COMPLETED, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE CARRIER.

Guarantor Last Name________________________________First_____________________MI_________

Address_______________________________________City____________________________

State______Zip Code________________Phone#_____________________________________

Date of Birth______________________Social Security#________________________________

Guarantor Employer___________________________________Employer Phone#____________________

Address____City_____________________________State________

DID A PHYSICIAN REFER YOU TO THIS OFFICE? YES________ NO_________

Physician Name_______________________________Address____

City______________________State_____ZipCode_______________Phone#_______________________

PLEASE TURN OVER AND COMPLETE OTHER SIDE.

If you were not referred by a physician, please indicate who you were referred by (friend, lawyer, insurance carrier, etc):

Referred By ____

Primary Care Physician________________________________Phone#____________________________

Address____City___________________State____Zip Code___________

Would you like your primary care physician to receive a copy of your office visit notes for today's visit?

YES ________ NO __________

I hereby authorize the physician to release any and all information or x-rays acquired in the course of my examination or treatment in this office to my insurance carrier, personal physician, or employer. I hereby authorize benefits to be paid directly to THE SPINE CENTER. I UNDERSTAND THAT PAYMENT OF CHARGES IS NOT CONTINGENT UPON A SETTLEMENT FROM MY INSURANCE CARRIER, AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

TODAY'S DATE_________________SIGNATURE____
(Patient or Guardian of Minor)