THE SPINE + PAIN INSTITUTE

PATIENT INFORMATION

Date: _____ Account Number: _____

Patient Full Name: _____ DOB: _____ Age: _____

Sex: ☐ Female ☐ Male Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other: _____

Social Security Number: _____ Marital Status: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

May we contact you by e-mail, if so please list your email: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

What pharmacy do you use? _____ Pharmacy Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Spouse's Information:

Spouse's Name: _____ DOB: _____ SS#: _____

Family Physician Information:

Family Physician: _____ Phone: _____

Address: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Effective Date: _____

Policy Holder: _____ SS#: _____ DOB: _____

Group #: _____ ID#: _____

Secondary Insurance: _____ Effective Date: _____

Policy Holder: _____ SS#: _____ DOB: _____

Group #: _____ ID#: _____

We ask all patients to show their insurance cards and driver's license so that we may make copies of them. Should your name, insurance information, address or phone number change, please notify us. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and iternizations to assist in making collections from insurance carriers and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION:

I, _____ , hereby authorize The Spine and Pain Institute to furnish information to my insurance company concerning my present illness. I direct the insurer to pay, without equivocation directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges and if I no show for an appointment I will be responsible for the $25.00 no-show fee. A photocopy of this authorization will be as valid as the original.

Patient Signature: _____ Date: _____ Time: _____