SECTION 1: PATIENT

DATE: ______ / ______ / ______

This section refers to the PATIENT ONLY:

LEGAL NAME: ____
(Last) (First) (Middle) (Name you wish to be called)

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

HOME PHONE: (________) ______________ CELL PHONE: (________) ______________

WORK PHONE: (________) ______________ E-MAIL: ______________________

SEX: ☐ M ☐ F RACE: ____________ ETHNICITY: ____________ RELIGIOUS PREFERENCE: ____________

BIRTHDATE: ______ / ______ / ______ STATE OF BIRTH: ______________________

SOCIAL SECURITY NUMBER: ______________________

EMPLOYED (check one): ☐ YES ☐ NO ☐ DISABLED ☐ RETIRED ☐ STUDENT

PRESENT EMPLOYER NAME: ______________________

PRESENT EMPLOYER ADDRESS: ______________________

REFERRED BY: ______________________

MARITAL STATUS (check one): ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW/WIDOWER

SPOUSE NAME: ______________________ SPOUSE WORK NUMBER: (________) ______________

EMERGENCY CONTACT NAME: ______________________ NUMBER: (________) ______________

EMERGENCY CONTACT RELATIONSHIP: ______________________

WERE YOU INJURED AT WORK: ☐ YES ☐ NO IF YES, DATE OF INJURY: ______ / ______ / ______

EMPLOYER AT TIME OF INJURY: ______________________

WERE YOU INJURED IN AN AUTO ACCIDENT: ☐ YES ☐ NO IF YES, DATE OF INJURY: ______ / ______ / ______

PLEASE COMPLETE THE BACK OF THIS FORM

SECTION 2: PRIMARY SUBSCRIBER OF INSURANCE
(Self / Parent / Spouse / Domestic Partner) if self, skip

LEGAL NAME: ____
(Last) (First) (Middle) (Name you wish to be called)

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

HOME PHONE: (_______) ______________ CELL PHONE: (_______) ______________

WORK PHONE: (_______) ______________ E-MAIL: ______________________

SEX: ☐ M ☐ F BIRTHDATE: _____ / _____ / _____ SOCIAL SECURITY NUMBER: ______________

EMPLOYED (check one): ☐ YES ☐ NO ☐ DISABLED ☐ RETIRED

PRESENT EMPLOYER NAME: ____

PRESENT EMPLOYER ADDRESS: ____

CONFIDENTIALITY CLAUSE:

I authorize Advanced Spine Institute to release medical information within the network of the Advanced Spine Institute Physicians and to:

____

their relationship to me is ____

______________________________ ______________

Patient / Parent / Spouse / Guarantor Signature Date

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I authorize the treating physician to furnish information to insurance carrier concerning my illness and treatments, and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Further, I understand I am responsible for payment on your account in full, if in three months from the date of service, my insurance company has not yet paid. I am also responsible regardless of any litigation.

______________________________ ______________

Patient / Parent / Spouse / Guarantor Signature Date

SIGNATURE ON FILE FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made on my behalf to the treating physician(s) for any services furnished me by that physician(s); I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

______________________________ ______________

Patient / Parent / Spouse / Guarantor Signature Date

CO-PAYS ARE EXPECTED AT THE TIME OF THE OFFICE VISIT