



PATIENT INFORMATION FORM

Your patience and cooperation in supplying us with complete and accurate information is very much appreciated. We rely on this data in the event that we need to contact you regarding laboratory reports, prescription information and various other medical necessities that may occur. Please notify the Front Desk Receptionist if you require assistance in completing this form. Language Spoken:

Appointment with Dr. _____ on ____/____/____ Translator Necessary Yes No

Last Name		First		Middle initial / Maiden Name		Date of Birth		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Home Phone # ()	
Mailing Address						Apt. / Lot		City		State/Zip	
Alternate Mailing Address						Apt. / Lot		City		State/Zip	
Material Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single		Widowed Separated		Mother's Name (If Minor Patient)				Father's Name (If Minor Patient)			
Occupation of Patient		Employer/Company Name				Employer Address				Employers Phone # ()	
Spouse's Name		Spouses Social Security#		Spouses Employer		Spouses Employer Address				Spouses Employers Phone# ()	
Allergies:								Do You Drink? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do You Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE INFORMATION

INSURANCE INFORMATION *Please write information about the patient's insurance here*

Primary Insurance Company Name				Secondary Insurance Company Name							
Insurance Company Address				Insurance Company Address							
City		State		Zip		City		State		Zip	
Insurance ID Number		Group Plan Number		Insurance ID Number		Group Plan Number					

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

*Is the secondary policyholder the: Patient Primary Policyholder Other
(Complete the information below if you checked "Other")*

Primary Policyholder's Name (Last, First, Middle Initial)				Date of Birth				Secondary Policyholder's Name (Last, First, Middle Initial)				Date of Birth			
Primary Policyholder's Address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female				Secondary Policyholder's Address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
City		State		Zip		Telephone ()		City		State		Zip		Telephone ()	
Employer's Name or School Name				Telephone				Employers Name or Schools Name				Telephone ()			
Employer's Address								Employer's Address							
City		State		Zip				City		State		Zip			
Social Security Number				Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other				Social Security Number				Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other			
Employer Plan Coverage		If Champus; <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled		<input type="checkbox"/> Yes <input type="checkbox"/> No		Branch of Service _____		Employer Plan Coverage		If Champus; <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled		<input type="checkbox"/> Yes <input type="checkbox"/> No		Branch of Service _____	

GUARANTOR INFORMATION

Head of Household/Custodial Parent of Minor Child				Relationship to Patient				Guarantor's Social Security #							
Mailing Address				Apt/Lot				City				State/Zip			
Guarantor Employer				Employer's Address				City				State/Zip			
Guarantor's Occupation				Drivers License #				Person Completing Form/Relationship to Patient							

(Please complete reverse side)

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **SpinalAid** to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claim.

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier(s) to make payment directly to **SpinalAid** for the surgical and/or medical benefits payable for the services rendered.

PATIENT SIGNATURE

INSURED'S SIGNATURE

Date

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME SERVICE IS RENDERED.

If this account is assigned to and attorney/or outside agency for collection and/or suit, **SpinalAid** shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

GUARANTOR'S SIGNATURE

Date

HOW DID YOU HEAR ABOUT US?

- Referral by _____
- Commercial TV/Radio
- Newspaper
- Flyer/insert
- Other _____
- Website
- Billboard
- Counter Display
- Telephone Directory

IN CASE OF AN EMERGENCY:

-- WHO SHOULD WE CONTACT --
(Please list someone living at a residence other than those listed on the reverse side.)

City: _____

State: _____

Relationship _____

Address: _____

Night () _____

Name: _____

Day () _____

Telephone _____