THE SPINE INSTITUTE

PATIENT #	
DOCTOR	

Please complete entire form before submitting.

PATIENT INFORMATION (Please Print)

PATIENT'S NAME	MARITAL STATUS S ☐ M ☐ W ☐ D ☐ SEP ☐	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE # (AREA CODE)

PATIENT'S EMPLOYER	EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUSINESS PHONE # OR CELL PHONE

SPOUSE OR GUARANTOR'S NAME/RELATIONSHIP	SPOUSE OR GUARANTOR'S EMPLOYER	DOB	SOCIAL SECURITY NUMBER

HOW LONG EMPLOYED	BUSINESS PHONE #	EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

GUARANTOR'S STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE #

FOR EMERGENCY PURPOSES: PLEASE GIVE NAME AND TELEPHONE NUMBER OF NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU / RELATIONSHIP

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT ☐	STREET ADDRESS, CITY, STATE & ZIP

DAY & EVENING PHONE # (Please give area code)	RAILROAD RETIREMENT ☐ YES ☐ NO

NAME OF PRIMARY INSURANCE ☐	EFFECTIVE DATE	I.D. #	GROUP #

ADDRESS OF COMPANY	PHONE #

MEMBER'S NAME	MEMBER'S ADDRESS, CITY, STATE, ZIP

NAME OF SECONDARY INSURANCE ☐	EFFECTIVE DATE	I.D. #	GROUP #

ADDRESS OF COMPANY	PHONE #

MEMBER'S NAME	MEMBER'S ADDRESS, CITY, STATE, ZIP

WORK COMP. ☐	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	CLAIM #
ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY

REFERRED BY (Physician's name & address)	FAMILY PHYSICIAN (Name & address)

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE THE SPINE INSTITUTE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS OF HEALTH SERVICES FOR THE ABOVE PATIENT AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FORM MY INSURANCE CARRIER. I REALIZE THAT THE INSURANCE PAYMENTS DO NOT ALWAYS COVER ALL FEES AND THAT I AM RESPONSIBLE FOR ANY PART NOT COVERED.

Signature of Responsible Party		**Date**	