THE SPINE INSTITUTE

Please complete entire form

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)

ARE YOU CURRENTLY LIVING IN A SKILLED NURSING FACILITY OR USING A HOME HEALTH AGENCY? ☐ YES ☐ NO

NAME OF FACILITY/AGENCY ADDRESS PHONE

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

OCCUPATION (INDICATE IF STUDENT) / HOW LONG? / EMAIL	BUSINESS PHONE # OR CELL PHONE

WORK STATUS:
EMPLOYED: FULL TIME ☐ PART TIME ☐ RETIRED ☐ STUDENT ☐ DISABILITY ☐

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

EMPLOYER

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

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

IS YOUR VISIT DUE TO AN INJURY ON THE JOB? ☐ YES ☐ NO	IS YOUR VISIT DUE TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO

DATE OF ACCIDENT	ATTORNEY NAME	CLAIM #	PHONE #

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 FROM 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**	