

## Patient Information

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In Case of Emergency Please Contact: \_\_\_\_\_ Home: \_\_\_\_\_ Alt.: \_\_\_\_\_

## Parent/Gaurdian Information if Patient is a Minor

Father/Gaurdian Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address (If different from patient's): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother/Gaurdian Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address (If different from patient's): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

## Health Insurance Information (Please present your card to Receptionist)

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## Accident Information (If Applicable)

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_  Worker's Comp  Auto Accident  Other

Part of Body Injured: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim or Policy#: \_\_\_\_\_ Name of Adjuster: \_\_\_\_\_

Employer (if different from above): \_\_\_\_\_ Phone: \_\_\_\_\_

## Assignment and Release of Information

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician or any of his staff responsible for any errors or omissions I have made in completing this form.

I hereby authorize the release of any medical information necessary to process my insurance claims to the above listed insurance companies. This may include information related to HIV, alcohol or substance abuse, mental health, or other medical conditions.

I hereby authorize payment of any medical benefits to go directly to the provider of service. I understand that I am responsible for any amounts not covered by my insurance plan. Furthermore, I agree to pay interest on any unpaid balance on my account in the amount of five percent (5%) per year. I also agree to pay all actual attorney fees, costs, and expenses incurred by the Brain + Spine Center PLC in attempting to collect any unpaid balance on my account.

Signature \_\_\_\_\_ Date: \_\_\_\_\_