

Premier Spine Care

Patient Registration Information

REFERRED BY: DOCTOR _____ PATIENT REFERRAL _____ OTHER _____

PATIENT INFORMATION

PATIENT LEGAL NAME: _____

PLEASE INCLUDE YOUR MIDDLE INITIAL

ADDRESS: _____

SS#: _____ BIRTHDATE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER NAME: _____ ADDRESS: _____

SPOUSE/EMERGENCY CONTACT INFORMATION

CONTACT NAME: _____ BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ WORKPHONE: _____ CELL PHONE: _____

DO YOU HAVE AN ADVANCE DIRECTIVE OR LIVING WILL? YES _____ NO _____

INSURANCE INFORMATION

*****PLEASE PROVIDE YOUR INSURANCE CARD(S) AND PHOTO ID TO COPY*****

PRIMARY INSURANCE (IF APPLICABLE):

INSURANCE PLAN: _____ POLICY #: _____ GROUP #: _____

SUBSCRIBER: _____ SUBSCRIBER BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER SS#: _____ EMPLOYER: _____

SECONDARY INSURANCE (IF APPLICABLE):

INSURANCE PLAN: _____ POLICY #: _____ GROUP #: _____

SUBSCRIBER: _____ SUBSCRIBER BIRTHDATE: _____ RELATIONSHIP: _____

SUBSCRIBER SS#: _____ EMPLOYER: _____

REFERRING PHYSICIAN INFORMATION

NAME: _____ ADDRESS: _____ PHONE: _____

PRIMARY CARE PHYSICIAN INFORMATION

NAME: _____ ADDRESS: _____ PHONE: _____

PATIENT CONFIDENTIALITY

I hereby authorize the release of medical information to _____ relationship _____

I hereby authorize Premier Spine Care to leave information on my voice mail at: (circle) HOME OFFICE CELL PHONE

I authorize the release of my medical records as needed to any physician, facility or other provider of service that Premier Spine Care asks to participate in my medical treatment. This authorization applies to all services until it is revoked by me or my representative.

PATIENT SIGNATURE: _____ DATE: _____

INSURANCE/SELF-PAY PATIENTS ONLY:

I hereby give authorization of insurance benefits to be made directly to Premier Spine Care, I understand that I am financially responsible for all the charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits; and agree that a photocopy of this agreement shall be as valid as original. I hereby authorize payment of my Medigap benefits to Premier Spine Care for all claims filed on my behalf.

PATIENT SIGNATURE: _____ DATE: _____