

Patient Information

Patient Name: _____ Birthdate: ____/____/____ Age: _____
 Address: _____ 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: _____