SouthernSpineSpecialists

NAME:_____

HOME PHONE: (_____)_____

WORK PHONE: (_____)_____ CELL PHONE: (_____)_____

ADDRESS:_____

CITY:_____STATE_____ZIP_____SS#:_____-_____-_____

E-MAIL ADDRESS:_____

SEX: (●) M ( ) F AGE:_____ DATE OF BIRTH:____/____/_____ MARITAL STATUS:_____

EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PARENT/SPOUSE'S NAME:_____RELATIONSHIP:_____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

SPOUSE'S EMPLOYER: _____BUSINESS PHONE: (_____)_____

EMERGENCY CONTACT:_____ PHONE: (_____)_____

REFERRING PHYSICIAN:_____ PHONE: (_____)_____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

OTHER DOCTORS YOU SEE REGULARLY: _____

WHAT PHARMACY DO YOU USE? _____----------_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

POLICY/ID # _____ GROUP # _____

HOLDER'S NAME: _____ HOLDER'S DATE OF BIRTH:____/____/_____

HOLDER'S SS#:_____-_____-_____ RELATIONSHIP TO HOLDER: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

POLICY/ID # _____ GROUP # _____

HOLDER'S NAME: _____ HOLDER'S DATE OF BIRTH:_____/_____/_____

HOLDER'S SS#:_____-_____-_____ RELATIONSHIP TO HOLDER: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize SOUTHERN SPINE SPECIALISTS, PLLC to release any information requested from the insurance with respect to claims and bills as the provider of the service rendered.

AUTHORIZATION TO PAY PROVIDER

I hereby authorize payment from the insurance to be sent directly to SOUTHERN SPINE SPECIALISTS, PPLC for services rendered. I understand that I am financially responsible for the charges that are not covered or considered not medically necessary by the insurance.

SIGNATURE:_____ DATE_____/_____/_____