SPINAL HEALTH GROUP

Caring is the heart of our commitment

PATIENT INFORMATION

Date______________________

Name____

Street Address____

City________________________ State_________ Zip________________

Home Telephone (_____)____________ SS#____________________

Cell phone (_____)___________ Email________________________

Birth date__________________________ Age_________ Sex_________

○Married ○Single ○Widowed ○Divorced No.of Children__________

Present Family Doctor______________________ Phone______________

Address____

EMPLOYMENT INFORMATION

Employer__________________________

Address___________________________

City __________ Zip________________

Phone # (_____)____________________

Occupation_________________________

SPOUSE INFORMATION

Spouse Name______________________

Spouse SS#_______________________

Occupation________________________

Employer__________________________

Office Phone # (_____)______________

ACCOUNT INFORMATION

How did you hear of us?___________________________________

____

Person ultimately responsible for account:

Name_________________________________ SS#________________

Relation_________________________________

Billing Address____

__________________________________ Phone # (_____)___________

EMERGENCY INFORMATION

Emergency Name__________________

Relationship______________________

Phone # (_____)___________________

INSURANCE INFORMATION

Primary Insurance Company Name________________________________ Phone # (_____)__________________

Address____ City________________ State________ Zip__________

Relationship to patient ○ Self ○ Spouse ○ Child ○ Other___________________________

Name of Insured Person____

Address____ City________________ State________ Zip__________

Phone # of Insured (_____)_______________________ SS# of Insured Person___________________________

Insurance Group Name__________________________________ Group or Policy Number___________________

Insurance Policy ○ Health ○ Automobile ○ Other______________________

Claim Number if Accident_______________________________________ Accident Date____________________

Was Accident due to ○ Employment ○ Auto ○ Other_________ Is there an Accident Report ○ Y ○ N

Attorney____ Attorney Phone # (_____)__________________

DESIRED METHOD OF PAYMENT

○ Cash ○ Check ○ Credit Card

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature________________________________ Date_______________