

PLEASE PRINT

DATE: _____

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MI: _____

PATIENT STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ WORK NUMBER: _____ CELLPHONE: _____

EMAIL ADDRESS: _____ HOW DID YOU HEAR ABOUT US? _____

PATIENT DATE OF BIRTH: _____ AGE: _____ SEX: M / F SS#: _____

PATIENT EMPLOYER: _____ PHONE#: _____ Ext#: _____

EMPLOYER ADDRESS: _____

MARITAL STATUS: S M W D

NAME OF DOCTOR WHO REFERRED YOU: _____ CITY: _____ PHONE# _____

NAME OF NEAREST RELATIVE
NOT LIVING WITH YOU: _____ RELATIONSHIP: _____ PHONE# _____

IS THIS OFFICE VISIT DUE TO AN ACCIDENT? YES OR NO

DATE OF INJURY: _____ Auto Workers' Comp Other

ATTORNEY'S NAME: _____ PHONE NUMBER: _____

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY

CONSENT FOR TREATMENT: I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.

INSURANCE BENEFITS: I hereby authorize SOUTH FLORIDA SPINE CLINIC, INC., to release any information acquired in the course of my examination and/or treatment to Social Security Administration & Health Care Financing Administration or its intermediaries or carriers, any information needed for Medicare, MEDIGAP, or other insurance claims. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits either to myself or to the party who accepts assignment. This is a lifetime authorization. I agree to pay in full for all medical services rendered by S.F.S.C. INC. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees.

HEALTH INSURANCE INFORMATION

INSURANCE CARRIER NAME: _____

SUBSCRIBERS NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBERS SS# _____

PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE OTHER:

PATIENT SIGNATURE: **X** _____