Patient Information

Today's Date:____/____/____

Name:__________________ ____ _______________________ Age:________ Date of Birth:_____/___/___
(First) (M.) (Last)

Male_____ Female_____ Height______ Weight________ SS #:_________-____-________

Address:____ City_________________ State__________ Zip_________

Telephone: Home (_____) - _______-_________ Work (_____) - _______ - _________ Cell (_____)_____-_________

Spouse/Parent Name: ____________________________ Date of Birth:____/____/____ SS#: _______- ____- _______

Referred by : Name_________________________________ Telephone: (____) - ______ - ___________

Address:______________________________ City__________________ State________ Zip_________

Family Physician: Name_________________________________ Telephone: (____) - ______ - ___________

Address:______________________________ City__________________ State________ Zip_________

Occupation:____

Employer: Name _________________________________ Telephone: (____) - ______ - ___________

Address:______________________________ City__________________ State________ Zip_________

Marital Status:____________________________

Injury/Illness : (Please circle one) Motor Vehicle Worker's Compnsation Neither

Primary Insurance

Policy Holder: Name_______________________________ Relationship: Self ( ) Spouse ( ) Child ( )

Name:_____________________________________ Telephone: (____) - _____-_______

Address:_________________________________ City_____________________ State______ Zip_________

ID #:______________________ Group #:________________________ Claim #:_____________________

Adjuster:____________________________________ Date of Accident: ____________________

Telephone (____) - _____ - _______ Fax: (____) - _____ - _______

Secondary Insurance

Policy Holder: Name_______________________________ Relationship: Self ( ) Spouse ( ) Child ( )

Name:_____________________________________ Telephone: (____) - _____-_______

Address:_________________________________ City_____________________ State______ Zip_________

ID #:______________________ Group #:________________________

Date of Injury / Onset of Complaint _____/_____/_____

Chief Complaint:____

How did injury occur: ____

____

____

Treatment to date: ____

____

____

Previous doctors treating this condition: ____

____

Past Medical History: ____

____

____

Past Surgical History: ____

____

____

Medications:____

____

Allergies: ____

____

Do you smoke? Yes No If yes, how many packs per day?_____________________

Are you presently working? Yes No If not, when did you stop working?___________________________________

I authorize the release of medical information, when necessary, to process insurance claims. In the event my insurance company denies any claim, I understand I am responsible for any expenses incurred.

Signature____(Parent's signature if patient is a minor.)

I authorize my insurance company to pay my benefits directly to Atlantic Spine Specialists if I have an outstanding balance on my account. I realize that I am responsible for payment in full.

Signature____(Parent's signature if patient is a minor.)