PREMIER SPINE CARE PATIENT REGISTRATION INFORMATION

Patient Information

Patient Legal Name _____
Please include your middle initial

Address _____ **City** _____ **State** _____ **Zip** _____

SSN# _____ **Birth Date** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Employer Name _____ **Address** _____

Email _____

Marital Status *(check one)* ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

Ethnicity *(check one)* ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic Or Latino
☐ Native Hawaiian ☐ White ☐ Other ☐ Refuse To Report

Primary Language _____

Spouse Information

Name _____

SSN# _____ **Birth Date** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Emergency Contact Information

Name _____ **Birthdate** _____

Relationship To Patient _____ **Cell Phone** _____ **Work Phone** _____

Do You Have An Advance Directive Or Living Will? ☐ Yes ☐ No

PREMIER SPINE CARE

Insurance Information

Primary Insurance (If Applicable)

Insurance Provider _____ Policy # _____ Group # _____

Primary Account Holder _____ Birth Date _____ Relationship _____

Primary Account Holder SSN _____ Employer _____

Secondary Insurance (If Applicable)

Insurance Provider _____ Policy # _____ Group # _____

Primary Account Holder _____ Birth Date _____ Relationship _____

Primary Account Holder SSN _____ Employer _____

Referring Physician Information

Name _____ Address _____ Phone _____

Primary Care Physician Information

Name _____ Address _____ Phone _____

Patient Confidentiality

I Hereby Authorize The Release Of Medical Information To Relationship _____

I Hereby Authorize Premier Spine Care To Leave Information On My Voice Mail At *(Check One)*

☐ Home Phone ☐ Cell Phone ☐ Work Phone

I Authorize The Release Of My Medical Records As Needed To Any Physician, Facility Or Other Provider Of Service That Premier Spine Care Asks To Participate In My Medical Treatment. This Authorization Applies To All Services Until It Is Revoked By Me Or My Representative.

_____

Patient's Name *(print)* Date

Insurance/Self-Pay Patients Only

I Hereby Give Authorization Of Insurance Benefits To Be Made Directly To Premier Spine Care, I Understand That I Am Financially Responsible For All The Charges Whether Or Not They Are Covered By Insurance. In The Event Of Default, I Agree To Pay All Costs Of Collection And Reasonable Attorney's Fees. I Hereby Authorize This Healthcare Provider To Release All Information Necessary To Secure Payment Of Benefits; And Agree That A Photocopy Of This Agreement Shall Be As Valid As Original. I Hereby Authorize Payment Of My Medigap Benefits To Premier Spine Care For All Claims Filed On My Behalf.

_____

Patient's Name *(print)* Date