SpinalAid CENTERS OF AMERICA

PATIENT INFORMATION FORM

Your patience and cooperation in supplying us with complete and accurate information is very much appreciated. We rely on this data in the event that we need to contact you regarding laboratory reports, prescription information and various other medical necessities that may occur. Please notify the Front Desk Receptionist if you require assistance in completing this form. Language Spoken:

Appointment with Dr. _____ on _____/_____/_____ Translator Necessary ☐ Yes ☐ No

Last Name	First	Middle initial / Maiden Name	Date of Birth	Sex ☐ Male ☐ Female	Home Phone # ( )
Mailing Address	Apt. / Lot	City	State/Zip	How Long At Present Address?	Social Security #
Alternate Mailing Address	Apt. / Lot	City	State/Zip	How Many Months at this Address?	

Material Status: ☐ Divorced ☐ Married ☐ Widowed ☐ Single ☐ Separated	Mother's Name (If Minor Patient)	Father's Name (If Minor Patient)	Drivers License #
Occupation of Patient	Employer/Company Name	Employer Address	Employers Phone # ( )
Spouse"s Name	Spouses Social Security# / Spouses Employer	Spouses Employer Address	Spouses Employers Phone# ( )
Allergies:		Do You Drink? ☐ Yes ☐ No	Do You Smoke ☐ Yes ☐ No

INSURANCE INFORMATION

INSURANCE INFORMATION *Please write information about the patient's insurance here*

Primary Insurance Company Name	Secondary Insurance Company Name
Insurance Company Address	Insurance Company Address
City / State / Zip	City / State / Zip
Insurance ID Number / Group Plan Number	Insurance ID Number / Group Plan Number

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

Is the secondary policyholder the: ☐ *Patient* ☐ *Primary Policyholder* ☐ *Other*
(Complete the information below if you checked "Other")

Primary Policyholder's Name (Last, First, Middle Initial) / Date of Birth / /	Secondary Policyholder's Name (Last, First, Middle Initial) / Date of Birth / /
Primary Policyholder's Address / Sex ☐ Male ☐ Female	Secondary Policyholder's Address / Sex ☐ Male ☐ Female
City / State / Zip / Telephone ( )	City / State / Zip / Telephone ( )
Employer's Name or School Name / Telephone	Employers Name or Schools Name / Telephone ( )
Employer"s Address	Employer"s Address
City / State / Zip	City / State / Zip
Social Security Number / Relationship to Patient ☐ Spouse ☐ Parent ☐ Other_____	Social Security Number / Relationship to Patient ☐ Spouse ☐ Parent ☐ Other_____
Employer Plan Coverage ☐ Yes ☐ No / If Champus; ☐ Active ☐ Retired ☐ Disabled / Branch of Service _____	Employer Plan Coverage ☐ Yes ☐ No / If Champus; ☐ Active ☐ Retired ☐ Disabled / Branch of Service_____

GUARANTOR INFORMATION

Head of Household/Custodial Parent of Minor Child	Relationship to Patent	Guarantor's Social Security #
Mailing Address / Apt/Lot	City / State/Zip	Guarantor's Phone # ( )
Guarantor Employer / Employer's Address	City / State/Zip`	Employer's Phone # ( )
Guarantor's Occupation / Drivers License #	Person Completing Form/Relationship to Patient	

(Please complete reverse side)

INSURANCE ASSIGNMENT OF BENEFITS

- ***AUTHORIZATION TO RELEASE INFORMATION:***
  I hereby authorize ***SpinalAid*** to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claim.

- ***AUTHORIZATION TO PAY BENEFITS:***
  I hereby authorize my insurance carrier(s) to make payment directly to ***SpinalAid*** for the surgical and/or medical benefits payable for the services rendered.

_____ _____

PATIENT SIGNATURE INSURED'S SIGNATURE

Date_____

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME SERVICE IS RENDERED.

If this account is assigned to and attorney/or outside agency for collection and/or suit, ***SpinalAid*** shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT SIGNATURE GUARANTOR'S SIGNATURE

Date _____

HOW DID YOU HEAR ABOUT US?

❑ Referral by_____ ❑ Counter Display ❑ Telephone Directory

❑ Website ❑ Billboard

❑ Commercial TV/Radio ❑ Newspaper ❑ Flyer/insert Other_____

IN CASE OF AN EMERGENCY:

-- WHO SHOULD WE CONTACT --
(Please list someone living at a residence other those listed on the reverse side.)

Name:_____ Telephone Day (___)_____

Address: _____ Night (___)_____

City: _____ State: ____ Relationship _____

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