Brain and Spine Medical Services, PLLC

PATIENT INFORMATION:						
FIRST NAME MI LAST NAME			SS#	SEX M F	AGE	BIRTH DATE
STREET ADDRESS			CITY		STATE	ZIP
HOME PHONE	WORK PHONE	CELLPHONE	EMAIL			

EMPLOYMENT STATUS:			
❑ **FULL TIME / ❑ PART TIME / ❑ UNEMPLOYED / ❑ RETIRED**			
IF EMPLOYED: EMPLOYER NAME			
EMPLOYER ADDRESS	CITY	STATE	ZIP
EMPLOYER PHONE	POSITION		

EMERGENCY CONTACT INFORMATION:			
FIRST NAME MI LAST NAME	RELATIONSHIP TO PATIENT		
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELLPHONE	EMAIL

REFERRING PHYSICIAN:			
FIRST NAME LAST NAME	SPECIALTY		
STREET ADDRESS	CITY	STATE	ZIP
PHONE	FAX NUMBER		

PRIMARY CARE PHYSICIAN:			
FIRST NAME LAST NAME			
STREET ADDRESS	CITY	STATE	ZIP
PHONE	FAX NUMBER		

Print Name_____ **Signature**_____ **Date**_____

PLEASE COMPLETE PAGES 1 AND 2 TO PROCESS

WORKERS COMPENSATION OR NO FAULT INSURANCE INFORMATION:

IS THIS A WORK RELATED INJURY? **YES** **NO** (PLEASE CIRCLE)	DATE OF INJURY
IS THIS AN AUTOMOBILE INJURY? **YES** **NO** (PLEASE CIRCLE)	DATE OF INJURY
IF YOU CIRCLED YES TO EITHER OF THE ABOVE PLEASE COMPLETE:	
IS THIS AN OPEN CASE? **YES** **NO** (PLEASE CIRCLE)	NAME OF YOUR ATTORNEY

WORKERS COMPENSATION OR NO FAULT INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
CLAIM # / WORKERS COMP BOARD #	CARRIER #		
CLAIM REPRESENTATIVE	PHONE		
EMPLOYER AT TIME OF INJURY			
ADDRESS	CITY	STATE	ZIP

PRIMARY MEDICAL INSURANCE:

INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

SECONDARY MEDICAL INSURANCE:

INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

AGREEMENT AND ACKNOWLEDGEMENT

I understand and agree that as part of my treatment plan, it may become necessary to disclose my protected health information to other entities to assist with my medical care and billing. I consent to such disclosure. In the event that my insurer determines the service is "not covered" by the terms of my health care plan, I accept responsibility for payment in full.

Print Name_____ Signature_____ Date_____

Please list family and friends involved in your medical care and/or payment of your medical bills to whom you authorize Brain and Spine Medical Services, PLLC to speak with and to disclose information to.

Name_____ Name_____

Name_____ Name_____