The Advanced Spine Center

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	SEX ☐M ☐F	MARITAL STATUS ☐M ☐W ☐S ☐D ☐CU	
EMAIL ADDRESS	PHONE # TO BEST CONTACT YOU: ☐Home ☐Work ☐Cell	ETHNICITY ☐ **Latino/Hispanic** ☐ **Other** ☐ **Not Reported/Refused**			
PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER			RACE		
REFERRING PHYSICIAN, ADDRESS & PHONE NUMBER			LANGUAGE		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #	
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP	
EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL ☐ OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Advanced Spinal Care & Associates LLC "dba: The Advance Spine Center", all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient's representative

Date