

WEST AUGUSTA SPINE SPECIALISTS

PLEASE PRINT

REFERRED BY _____

NAME _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF YOU USE A POST OFFICE BOX PLEASE LIST HERE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ SOC. SEC. # _____

DATE OF BIRTH _____ AGE _____ RACE B W O SEX M F Married Divorced Widowed Single

EMPLOYER NAME _____ ADDRESS _____

SPOUSE/PARENT NAME _____ SPOUSE/PARENT SOC. SEC. # _____ SPOUSE DATE OF BIRTH _____

IN AN EMERGENCY, PLEASE NOTIFY (OTHER THAN SPOUSE)

NAME _____ RELATIONSHIP _____ PHONE (_____) _____

DRUG ALLERGIES: _____

PAST MEDICAL PROBLEMS: _____

COMPLAINT TODAY: _____

DATE OF FIRST SYMPTOMS: _____ AUTO ACCIDENT W/C OTHER

INSURANCE INFORMATION

PLEASE NOTE - PRE-CERTIFICATION IS THE PATIENT'S RESPONSIBILITY

| | |
|---------------------------|---|
| PRIMARY INSURANCE: | IS PRE-CERTIFICATION REQUIRED? <u>YES</u> <u>NO</u> |
| NAME OF INSURANCE _____ | NAME OF INSURED: _____ |
| POLICY # _____ | INSURED'S DATE OF BIRTH: _____ |
| GROUP# _____ | RELATIONSHIP TO PATIENT: _____ |
| INSURED'S _____ | MAIL CLAIM TO: _____ |
| EMPLOYER NAME _____ | ADDRESS: _____ |

| | |
|-----------------------------|---|
| SECONDARY INSURANCE: | IS PRE-CERTIFICATION REQUIRED? <u>YES</u> <u>NO</u> |
| NAME OF INSURANCE _____ | NAME OF INSURED: _____ |
| POLICY # _____ | INSURED'S DATE OF BIRTH: _____ |
| GROUP# _____ | RELATIONSHIP TO PATIENT: _____ |
| INSURED'S _____ | MAIL CLAIM TO: _____ |
| EMPLOYER NAME _____ | ADDRESS: _____ |

WORKERS' COMPENSATION INFORMATION

| | |
|-----------------------|----------------------|
| W/C CARRIER _____ | DATE OF INJURY _____ |
| W/C ADDRESS _____ | W/C PHONE _____ |
| DESCRIBE INJURY _____ | |

CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT FOR EXAMINATION/TREATMENT: I HEREBY AUTHORIZE AND CONSENT TO SUCH EXAMINATIONS AND TREATMENTS BY WEST AUGUSTA SPINE SPECIALISTS AS MAY BE ORDERED BY THE DOCTOR IN CHARGE OF THIS CASE.

DATE: _____ SIGNATURE: _____

RELEASE OF MEDICAL INFORMATION: I HEREBY AUTHORIZE WEST AUGUSTA SPINE SPECIALISTS TO RELEASE MEDICAL INFORMATION AND OTHER INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT TO MY INSURANCE COMPANY, CLAIMS REPRESENTATIVE, ADJUSTOR, OTHER PHYSICIANS AND/OR ATTORNEY.

DATE: _____ SIGNATURE: _____

ASSIGNMENT OF MEDICAL/HEALTH BENEFITS

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS. I AGREE TO PAY ALL MEDICAL SERVICE CHARGES NOT COVERED BY INSURANCE.