US Pain & Spine Institute™

Name (last, first) ___________________, ______________________ DOB _______________

Address _____________________________ City ______________ State _______ Zip __________

SS# _________-_____-____________ Marital Status _________ Gender: _____Female _____Male

Phone- Home: __________________Work: ___________________ Cell: ____________________

E-mail Address: ____@____

Employer: _________________________________ Occupation: ______________________ Yrs. Employed: ______

Referring Physician: _______________________________________ Phone: __________________________________

Address ____

Primary Care Physician: ____________________________________Phone: __________________________________

Address ____

Therapist/Counselor: ___________________________________ Phone: __________________________________

Address ____

EMERGENCY CONTACT

Name ____ Relationship _____________________________

Home Phone: _________________________ Work: ________________________ Cell: _______________________

INSURANCE INFORMATION (*__all blanks must be filled in__*) Please provide insurance card(s) on day of visit.

[ ] SELF- PAY **[ ] WORKER'S COMP** **[ ] INSURANCE**

Primary INS Name: ____ Policy Holder: _____________________________

ID: ____ Group: _____________________________________

SS# of policy holder _________-_____-____________ DOB of Policy Holder: ________________

Employer of Policy Holder ____________________________ Relationship to Patient _________________

Secondary INS Name: ______________________________________ Policy Holder ______________________________

ID: ____ Group: ______________________________________

SS# of policy holder _________-_____-____________ DOB of Policy Holder: ________________

Employer of Policy Holder ____________________________ Relationship to Patient __________________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

Signature of Patient/Responsible Party: __________________________________ Date: ________________________