

# PATIENT REGISTRATION FORM

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

ACCOUNT # \_\_\_\_\_

Billing Code: \_\_\_\_\_ Resp Dr. # \_\_\_\_\_  New Pt.  Update DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ RESPONSIBLE PARTY FOR MINOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

HOME PH: \_\_\_\_\_ CELL / ALT PH: \_\_\_\_\_ BUS PH: \_\_\_\_\_ SEX:  Male  Female

PT. SS # \_\_\_\_\_ RESP PARTY SS #: \_\_\_\_\_ RELATIONSHIP TO PT:  Self  Spouse  Parent  Other

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PRIMARY CARE PHYSICIAN & ADDRESS: \_\_\_\_\_

IF INJURY IS RELATED TO AN ACCIDENT, Was it an:  Auto Accident  Job Related Injury DATE OF INJURY: \_\_\_\_\_

IS PATIENT:  SINGLE  MARRIED  OTHER IS PATIENT:  EMPLOYED  STUDENT  RETIRED

PT. EMPLOYER NAME AND ADDRESS: \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

PHONE / ADDRESS OF PERSON ABOVE: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR: \_\_\_\_\_ FIRST DATE OF SYMPTOMS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ ARE YOU PREGNANT?  Yes  No

## INSURANCE INFORMATION:

INDUSTRIAL / WORKMAN'S COMPENSATION

PRIMARY INSURANCE  
INSURANCE CO. NAME: \_\_\_\_\_

INS CO. ADDRESS: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO.: \_\_\_\_\_

POLICY HOLDER SEX:  F  M BIRTHDATE: \_\_\_\_\_

SECONDARY INSURANCE:  
INSURANCE CO. NAME: \_\_\_\_\_

INS CO. ADDRESS: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP/CLAIM NO.: \_\_\_\_\_

POLICY HOLDER SEX:  F  M BIRTHDATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS:** I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

SIGNED (patient or parent, if minor): \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO PAY:** I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO TREAT MINOR:** I hereby authorize the physician (s), physician assistants, technicians or other authorized medical personnel of Spine Institute of Arizona to treat the above patient.

SIGNED Patient (or Legal Guardian): \_\_\_\_\_ DATE: \_\_\_\_\_