PATIENT INFORMATION SHEET

PATIENT NAME: ____

MAIDEN NAME, IF APPLICABLE: ________________________________ NICKNAME: ___________________________

ADDRESS: ______________________________ CITY: _______________________ STATE: ______ ZIP: ________

STREET/SECONDARY ADDRESS IF PO BOX USED: ____

HOME PHONE: ___________________ ALT/CELL PHONE: ____________________ WORK PHONE: __________________

SS#: ________________ EMAIL: ____ MALE ❒ FEMALE ❒

DOB: ____________________ AGE: ____________ MARITAL STATUS: M ❒ S ❒ D ❒ W ❒

RACE: __________ ETHNICITY: _______________ PRIMARY/SECONDARY LANGUAGE: ________________________

WHAT IS YOUR DOMINANT HAND? ❒ RIGHT ❒ LEFT ❒ AMBIDEXTROUS SEXUAL ORIENTATION: _______________________

WOULD YOU LIKE INFO ON NEW SERVICES VIA EMAIL? ❒ YES ❒ NO

SPOUSE'S INFORMAITON:

SPOUSE'S NAME: ____

ADDRESS: ________________________________ PHONE #: _______________________ DOB: ______________

EMPLOYER NAME: ____ PHONE #: __________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE):

NAME: ____

RELATIONSHIP: ____________________________________ PHONE #: ______________________________________

ADDRESS: _______________________________ CITY: __________________ STATE: ___________ ZIP: ________

***WERE YOU INJURED ON THE JOB? YES / NO *IS THIS A MOTOR VEHICLE ACCIDENT? YES / NO Date of injury: __________**

***IS AN ATTORNEY/LEGAL INVOLVED IN ANY ASPECT RELATED TO THIS VISIT OR INJURY? YES / NO**

EMPLOYER INFORMATION:

CURRENT EMPLOYER: ____

ADDRESS: ______________________________ CITY: ______________________ STATE: __________ ZIP: ________

PHONE #: ___________________________ OCCUPATION: ____

PRIMARY CARE/ REFERRING/ TREATING PHYSICIAN (EVEN IF SENT FROM E.R.):

CLINIC NAME: ___________________________________ PHYSICAN NAME: ______________________________

ADDRESS: ____

PHONE #: ______________________________________ FAX #: ____

INSURANCE: ❒ PRIVATE ❒ WORKERS' COMP ❒ ATTORNEY/LEGAL ❒ OTHER: ______________________________

PRIMARY INSURANCE:

INS. NAME: __________________________ ID #: ___________________________ GROUP #: __________________

POLICY HOLDER'S NAME: __________________________________ DOB: _______________ SS #: _______________

RELATIONSHIP TO PATIENT: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER: ______________________________________

SECONDARY INSURANCE:

INS. NAME: __________________________ ID #: ___________________________ GROUP #: __________________

POLICY HOLDER'S NAME: __________________________________ DOB: _______________ SS #: _______________

RELATIONSHIP TO PATIENT: ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER: ______________________________________

…continued on next page

PATIENT NAME: ____ DOB: _________________________________

PHARMACY NAME, ADDRESS, PHONE: ____

BY SIGNING HERE, I'M PROVIDING CONSENT FOR THE RELEASE OF MY E-MED HISTORY TO YOU: _______________________________
(This helps to assure safe drug interactions, etc.)

PATIENT PRIVACY INFORMATION:

❒ YES, YOU MAY LEAVE A MESSAGE FOR ME ON MY PHONE ❒ NO, YOU MAY NOT LEAVE A MESSAGE ON MY PHONE

❒ YES, YOU MAY EMAIL MESSAGES FOR ME ❒ NO, YOU MAY NOT EMAIL MESSAGES FOR ME

I AUTHORIZE THE FOLLOWING PEOPLE ACCESS TO MY MEDICAL INFORMATION:

NAME 1: ____ DATE OF BIRTH: ____________________

RELATIONSHIP: ____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: ____

NAME 2: ____ DATE OF BIRTH: ____________________

RELATIONSHIP: ____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: ____

NAME 3: ____ DATE OF BIRTH: ____________________

RELATIONSHIP: ____

ALL SASPINE PROVIDERS I'VE SEEN ❒ OR ONLY: ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ❒ INTERNET ❒ PHYSICIAN REFERRAL ❒ FRIEND/ASSOCIATE ❒ MAGAZINE

❒ OTHER: ____

ASSIGNMENT FOR COVERED SERVICES: I CERTIFY THAT THE INFORMATION ABOVE, INCLUDING MY ID, IS CORRECT AND HEREBY REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO SASPINE, LLC, FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE SASPINE TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. IF MY INSURANCE FAILS TO PAY SASPINE FOR ANY REASON, INCLUDING COPAYS, DEDUCTIBLES, COINSURANCES, OR MY FAILURE TO REPORT CHANGES OF BENEFITS, I AGREE TO PAY ALL UNPAID BALANCES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY SASPINE, OF ANY CHANGES IN PERSONAL INFORMATION, OR CHANGES OF BENEFITS/TERMINATION, ETC.

SIGNATURE: ____ DATE: ________________________

PRINTED NAME: ____