# PATIENT REGISTRATION FORM

Auto Accident Y__ N__ Personal Injury Y__ N__

Last Name:_____ First Name:_____ M.I: __

Mailing Address:_____ City:_____ State:___ Zip:_____

Home#: (____)_____ Cell#:(____)_____ Work#:(____)_____

SSN:_____ DOB:_____ Sex: M F

Marital Status: S M W D O Spouse's Name _____

E-MAIL_____

Employer:_____ Occupation:_____

Employer Address: _____

Person to notify in case of emergency:_____ Phone:_____

Primary Care Physician: _____ Address: _____

Referring Physician: _____ Address: _____

Pharmacy Information:

Name_____

ADDRESS _____

TELEPHONE_____

## INSURANCE INFORMATION

Primary Insurance: _____ Subscriber:_____

SSN#:_____ Relationship:_____

Insurance Address:_____

City:_____ State:_____ Zip:_____ Group#:_____

Telephone: (_____) _____--_____ Extension:_____

ID#:_____

Secondary Insurance:_____ Subscriber:_____

SSN#:_____ Relationship:_____

Claims Address:_____ ID#:_____

City:_____ State:_____Zip:_____ Group#:_____

Telephone: (_____) _____--_____ Extension:_____

Assignment of Benefits - Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to COMPREHENSIVE SPINE AND SPORTS, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. In addition, I authorize the release of my records for peer review by physicians in order to ensure the highest quality of care is being provided to me.

Responsible Party:_____ Date_____