

Patient Information

Name:
Sex: Male Female Age:
Home Address:
City, State
Zip Code
e-mail:
Home Telephone #:
Cellular Telephone #:
Social Security #:
Date of Birth:
Marital Status:

Primary Care Physician

Name:
Doctor's phone #:
Office Address:
City, State
Zip Code

Patient's Occupation

Employer:
Address:
City, State
Zip Code
Work Telephone #/ ext:

For Office Use:	MR#
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Health Insurance Information

Primary insurance Carrier:
Insurance Carrier's Phone #:
Policy #:
Group #:
Name of Insured:
Insured's Date of Birth:
Insured's Social Security #:
Patient's Relationship to insured:
<i>Secondary</i> insurance:
<i>Secondary</i> Policy #:
<i>Secondary</i> Group #:
Is this an AUTO or WORKMAN'S COMP case? YES NO
If so, Case #:
Date of Injury:
Case Manager's Name:
Case Manager's Telephone #:

In Case of Emergency, Notify:

Name:
Relationship to Patient:
Home Address:
City, State
Zip Code
Home Telephone #:
Cellular Telephone #:

I hereby certify that the above information is correct and complete to the best of my knowledge, and that I personally will be held financially responsible for any medical services provided which have been denied due to lack of coverage or inability to identify the patient and/or subscriber in the insurance carrier's system.

I hereby further authorize Riverside Spine and Pain Physicians to release any and all private healthcare information (PHI) to my consulting physicians, referring physicians, primary care physicians or any other physicians involved in or potentially involved in my medical care.

Signature	Date
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