SPINE INSTITUTE OF CENTRAL FLORIDA

WORLD-CLASS SPINE CARE

EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY

Comprehensive Center of Excellence in ALL Spine Care & Pain Management

PATIENT INFORMATION

Date:__________________________ Cell Phone:_____________________ Home Phone:_________________________

Name:____ Soc. Sec. No: _________________________

LAST NAME FIRST NAME M.I.

Address: ____

City:____ State:__________________ Zip:_____________________

Sex: ☐ M ☐ F DOB:______________ Age:___________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer Name:___________________________________ Work Phone:_____________________________________

Referring Physician:_________________________________ Primary Care Physician:___________________________

LAST NAME FIRST NAME LAST NAME FIRST NAME

Emergency Contact:_________________________________Relationship:_____________ Phone:__________________

PRIMARY INSURANCE

Insurance Company:____ Phone Number:_________________________

Insured ID/Member Number: ___________________________________ Group Number: ________________________

Insurance Address: ____

Responsible Party:____ Relation to Patient:___________________________

DOB:__________________ Soc Sec No:______________________ Phone Number:______________________________

Address:____

City:____ State:_____________________ Zip:_________________________

*You must present the insurance card to our office for any insurance listed above. Otherwise, we will be unable to submit your medical claims to the insurance company listed.

ADDITIONAL INSURANCE

Insurance Company:____ Phone Number:_________________________

Insured ID/Member Number: ___________________________________ Group Number: ________________________

Insurance Address: ____

Responsible Party:____ Relation to Patient:___________________________

DOB:__________________ Soc Sec No:______________________ Phone Number:______________________________

Address:____

City:____ State:_____________________ Zip:_________________________

*You must present the insurance card to our office for any insurance listed above. Otherwise, we will be unable to submit your medical claims to the insurance company listed.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that (or my dependent) have active insurance coverage as listed above and assign all benefits to the Spine Institute of Central Florida, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Spine Institute of Central Florida to release all information, demographic and/or medical, necessary to secure the payments of benefits. I authorize the use of my signature on all insurance submission.

_______________________________________ ____________________________ ____________

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE