

PATIENT INFORMATION:						
FIRST NAME	MI	LAST NAME	SS#	SEX M F	AGE	BIRTH DATE
STREET ADDRESS			CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELLPHONE	EMAIL		PRIMARY LANGUAGE	
RACE: <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK/AFRICAN AMER. <input type="checkbox"/> AMER. INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWIIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER ETHNICITY: <input type="checkbox"/> SPANISH/HISPANIC ORIGIN <input type="checkbox"/> NOT SPANISH/HISPANIC ORIGIN <input type="checkbox"/> UNKNOWN						

EMPLOYMENT STATUS:			
<input type="checkbox"/> FULL TIME / <input type="checkbox"/> PART TIME / <input type="checkbox"/> UNEMPLOYED / <input type="checkbox"/> RETIRED			
IF EMPLOYED: EMPLOYER NAME			
EMPLOYER ADDRESS		CITY	STATE ZIP
EMPLOYER PHONE	POSITION		

EMERGENCY CONTACT INFORMATION:			
FIRST NAME	MI	LAST NAME	RELATIONSHIP TO PATIENT
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE	WORK PHONE	CELLPHONE	EMAIL

PRIMARY CARE PHYSICIAN:			
FIRST NAME	LAST NAME		
STREET ADDRESS		CITY	STATE ZIP
PHONE	FAX NUMBER		

REFERRING PHYSICIAN:			
FIRST NAME	LAST NAME	SPECIALTY	
STREET ADDRESS		CITY	STATE ZIP
PHONE	FAX NUMBER		

My primary decision to schedule an appointment was influenced by (check all that apply): REFERRING PHYSICIAN PRIMARY CARE PHYSICIAN
 ANOTHER PATIENT FRIEND FAMILY ONLINE SEARCH NEWSPAPER RADIO TV OTHER _____

Print Name _____	Signature _____	Date _____
------------------	-----------------	------------

PRIMARY MEDICAL INSURANCE:			
INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

SECONDARY MEDICAL INSURANCE:			
INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

WORKERS COMPENSATION OR NO FAULT INSURANCE INFORMATION:				
IS THIS A WORK RELATED INJURY?	YES	NO	(PLEASE CIRCLE)	DATE OF INJURY
IS THIS AN AUTOMOBILE INJURY?	YES	NO	(PLEASE CIRCLE)	DATE OF INJURY
IF YOU CIRCLED YES TO EITHER OF THE ABOVE PLEASE COMPLETE:				
IS THIS AN OPEN CASE?	YES	NO	(PLEASE CIRCLE)	NAME OF YOUR ATTORNEY
WORKERS COMPENSATION OR NO FAULT INSURANCE CARRIER NAME				
ADDRESS	CITY	STATE	ZIP	
CLAIM # / WORKERS COMP BOARD #	CARRIER #			
CLAIM REPRESENTATIVE	PHONE			
EMPLOYER AT TIME OF INJURY				
ADDRESS	CITY	STATE	ZIP	

AGREEMENT AND ACKNOWLEDGEMENT

I understand and agree that as part of my treatment plan, it may become necessary to disclose my protected health information to other entities to assist with my medical care and billing. I consent to such disclosure. In the event that my insurer determines the service is "not covered" by the terms of my health care plan, I accept responsibility for payment in full.

Print Name _____ Signature _____ Date _____

Please list family and friends involved in your medical care and/or payment of your medical bills to whom you authorize Brain and Spine Medical Services, PLLC to speak with and to disclose information to.

Name _____ Name _____

Name _____ Name _____