Welcome to our office!

PATIENT INFORMATION

Date _____
Patient Name _____ Social Security # ____-___-____
Birth Date _____ Age _____ □ M □ F
Address _____ City/State/Zip _____
Email _____
Marital Status _____ # children _____
Occupation _____
Employer _____
Who may we thank for referring you?
_____

CONTACT INFORMATION

Home Phone (____) _____ Cell phone (____) _____
Work phone (____) _____
Emergency contact (____) _____Emergency contact name _____
Relationship to patient _____

ACCIDENT INFORMATION

Is condition due to an auto accident? □ Yes □ No
Type of accident □ Auto □ Work □ Other
Attorney (if applicable) _____

PRIMARY INSURANCE

Insurance Co. _____ Phone number (____) _____
Mailing address _____ City/State/Zip _____
Policy # _____ Group # _____
Subscriber's Name _____ Subscriber's Birth date _____
relationship to subscriber _____ Effective date _____

SECONDARY INSURANCE (if applicable)

Insurance Co. _____ Phone number (____) _____
Mailing address _____ City/State/Zip _____
Policy # _____ Group # _____
Subscriber's Name _____ Subscriber's Birth date _____
relationship to subscriber _____ Effective date _____

I hereby authorize Advanced Spine Health and Wellness Center (ASHWC) to submit claims to my insurance carrier(s) on my behalf, and my insurance carrier(s) to make payments directly to ASHWC. I understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any service to my insurance carrier they are performing this service strictly as a convenience for me. ASHWC will provide any necessary reports or required information to aid in insurance reimbursement for services. In the event that any insurance carrier denies my claims, I understand that I am fully responsible for the payment of any unpaid balance. Any additional monies received will be credited to my account. I further authorize the release of any information, including medical records, to my insurance carrier(s) for the purposes of health care management and/or processing medical claims.

Patient/ Guardian Signature _____ Date _____