

Southeast Spine Care & Pain Management

Patient Name: _____
(Last) (First) (Middle)

Gender: Male Female DOB: _____ Age: _____

Marital Status: Single Married Widowed Student: Yes No Employed Yes No

Employer Name or School: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address if Different: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ - _____ - _____

Please complete if the patient is under the age of 18

Parent/Guardian Name: _____
(Last) (First) (Middle)

Parent/Guardian's mailing address if different from above: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security: _____ - _____ - _____ DOB: _____

Name of Primary Insurance Carrier: _____ N/A

Subscriber's Name: _____
(Last) (First) (Middle)

Subscriber's SSN: _____ - _____ - _____ Subscriber's Date of Birth: _____

Subscriber's mailing address if different from above: _____

Name of Secondary Insurance Carrier: _____ N/A

Subscriber's Name: _____
(Last) (First) (Middle)

Subscriber's SSN: _____ - _____ - _____ Subscriber's Date of Birth: _____

The signature below serves as authorization/consent for medical treatment by the physician or nurse. It also provides authorization to Southeast Spine Care & Pain Management to furnish and/or release any information necessary to your insurance carrier, third party administration, plan administrators, and or health benefit payor representatives in order to process health care claims. This authorization also serves as permission to release medical information at any time, when communicated in writing. I acknowledge that S.E. Spine Care & Pain Management will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I am financially responsible at the time of service for all co-payments, deductibles, balances not covered by the insurance carrier, and any previous balances owed.

Signature of Patient/Responsible Party: _____ Date: _____