# SCOLIOSIS ASSOCIATES

PATIENT INFORMATION

Patient Name_____ Home Phone#_____
Home Address_____ City_____ State_____ Zip_____
Sex M ☐ F ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐
Age_____ Birthdate_____ Social Security # of Patient_____

Patient Employed by_____ Address_____
Business Phone #_____ Occupation_____

Primary Physician_____ Referring Physician_____
Address_____ Address_____
City_____ State_____ Zip_____ City_____ State_____ Zip_____
Phone#_____ Phone#_____

Whom may we thank for referring you? (Please check all that apply and write in specifics)
Printed Advertisement ☐ Internet ☐ News Story ☐ Television ☐
Specifics_____

In case of emergency who should we notify_____ Phone#_____

(If A Minor) (If A Minor)
Mother's Name_____ Father's Name_____
Employed by_____ Employed by_____
Business Address_____ Business Address_____
Business Phone #_____ Business Phone #_____

## PRIMARY INSURANCE

IMPORTANT!! Please complete the section below for each insurance that you have. Please have your insurance card ready for us to copy. We also need referrals, authorizations and any test results.

Is this claim a result of an auto accident YES ☐ NO ☐ Accident Date_____
Is this claim a result of a work injury YES ☐ NO ☐ Accident Date_____

Insurance Company_____ Address_____
City_____ State_____Zip_____
Policy ID#_____ Group#_____
Telephone # of Insurance Co._____ Policy Holder_____
Sex of Policy Holder M__ F__ Patient Relation to Subscriber_____ Subscriber Bithdate_____

## SECONDARY INSURANCE

Insurance Company_____ Address_____
City_____ State_____Zip_____
Policy ID#_____ Group#_____
Telephone # of Insurance Co._____ Policy Holder_____
Sex of Policy Holder M__F__Patient Relation to Subscriber_____Subscriber Birthdate_____

## RELEASE

I authorize this office to release any medical information pertaining to medical history and/or information necessary to expedite insurance claims, and request direct payment of benefits to the above provider. I understand that I am responsible for all deductibles, co-pays, and cost shares as determined by my insurance coverage.
Patient, Parent or Guardian's Signature_____Date_____