PATIENT INFORMATION

Date_____________ Referring Physician ____
Primary Care Physician ____
If not referred, how did you hear about our office?_______________________________________
Name____Birthdate_______________
Sex__________Marital Status __________ Social Security # ________________________________
Address____City__________________________
State__________Zip_______________ Home phone ____
Work phone______________________Cell phone ____
Employers name____
Address____
Have you or anyone in your family ever been seen by one of the physician's of Spine Idaho/Idaho Neurosurgery & Spine? YES NO If so, WHO:____

Primary Insurance ____
Policy Holders Name ________________________________Birthdate________________________
Policy Number____Group#_________________
Secondary Insurance ____
Policy Holder Name _________________________________Birthdate________________________
Policy Number____Group#_________________

Responsible Party ____
Spouse or Responsible Parents Name______________________________Birthdate___________
Social Security # ___________________________Work phone ________________________________
Employer ____

Person to contact in case of an emergency
Name ____Phone #_______________________

WORK RELATED yes or no Date of Injury_____________Employer ___________________
Industrial Insurance Company ____
Case worker ____Phone # ___________________
Claim #________________________________
ACCIDENT Auto or other Date of Accident ____________Place of accident_______________
Insurance Company__________________________Claim #____________________________________
Agent_____________________________Phone#_________________________

PHYSICIAN SERVICES ASSIGNMENT: I HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS FOR PHYSICIAN SERVICES TO THE PHYSICIAN WHOSE STATEMENT IS ATTACHED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY GIVE PERMISSION TO THE PHYSCIANS TO EXAMINE AND RENDER TREATMENT. I GIVE PERMISSION AND CONSENT FOR RELEASE OF ALL NECESSARY MEDICAL RECORDS AND OTHER MEDICAL INFORMATION FOR TREATMENT AND BILLING PURPOSES.

SIGNATURE ____DATE ___________