SPINAL DIAGNOSTICS

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PATIENT INFORMATION

Please use an ink pen

Today's Date: _____

Name: _____ [ ] Male [ ] Female Date of Birth:_____
Address: _____ Telephone: (_____) _____
City: _____ State: _____ Zip: _____ SSN#_____-_____-_____
Employer: _____ Telephone: (_____) _____-_____
Mobile Ph # (_____) _____ Marital Status [ ]M [ ]S [ ]D [ ]W Spouse's Name: _____
Spouse's Work Telephone: (_____) _____ Spouse's Mobile#: (_____) _____
Preferred Language: _____ Ethnicity: _____ Hispanic/Latino: [ ]Yes [ ] No
E-MAIL: _____

EMERGENCY CONTACT, NEAREST RELATIVE OTHER THAN SPOUSE:

Name: _____ Relationship: _____Telephone:(_____) _____
Address: _____ City: _____ State: _____ Zip:_____

REFERRING PHYSICIAN OR SOURCE OF REFERRAL

Physician's Name: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Family Physician's Name: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Other Consulting Physicians: _____

INSURANCE INFORMATION

Are you being treated for a work related injury, motor vehicle injury or personal injury? [ ] Yes [ ] No
Primary Insurance Company _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Name: _____ [ ] Male [ ] Female Date of Birth: _____
Policy /ID #: _____ Group Name/#: _____ Employer: _____
Secondary Insurance Company: _____ Telephone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Name: _____ [ ] Male [ ] Female Date of Birth: _____
Policy/ID #: _____ Group Name/#: _____ Employer: _____

Present your insurance cards to submit a claim to your insurance company. We will need complete and detailed information in order to process your claim.

IF YOUR APPOINTMENT IS DUE TO WORK RELATED INJURY OR CONDITION:

Claim # or ID #: _____ Date of injury: _____
Name of Employer through which claim was filed: _____ Employer's Phone: (____) _____
Name of Employer's Insurance carrier: _____ Carrier's Phone: (_____) _____
Claims Examiner/Contact: _____ Phone No. (_____) _____
Insurance Carrier's Address: _____ City: _____ State: _____Zip: _____
What injury(s) did you sustain: _____

IF YOUR APPOINTMENT IS DUE TO AN AUTO ACCIDENT/PERSONAL INJURY:

Date Of Injury: _____ State in which accident occurred: _____ Insurance Co. _____
Phone #: (_____) _____ Insurance Carrier's Address: _____
City: _____ State: _____ Zip: _____ Insured's Name: _____
Policy # _____ Attorney's Name: _____
Address: _____ City: _____ State: _____ Zip: _____