SPINE & MUSCULOSKELETAL MEDICINE, P.C.

Patient's Demographic

Patient Legal Name:_____ Nickname:_____

Date of birth:_____ SSN#:_____ Race:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_(_____)_____-_____ Cell: _(_____)_____-_____ Work: _(_____)_____-_____

Patient's Employer:_____

Patient's Email Address:_____

Emergency Contact:_____ Phone: _(_____)_____-_____

Relationship to patient:_____

Family Doctor:_____ Family Doctor's Phone:_(_____)_____-_____

Family Doctor's Address_____

Primary Health Insurance

Policy Holder's Name:_____ Date of Birth:_____

Relation to Patient:_____ Policy Holder's SSN#:_____

Name of Insurance Company:_____

Policy ID:_____ Group #:_____

Secondary Health Insurance

Policy Holder's Name:_____ Date of Birth:_____

Relation to Patient:_____ Policy Holder's SSN#:_____

Name of Insurance Company:_____

Policy ID:_____ Group #:_____

Release of Information

I hereby authorize Spine & Musculoskeletal Medicine and its staff, to release to the above company(ies) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information

Assignment of Benefits

AUTHORIZATION: I authorize payment of benefits directly to Spine & Musculoskeletal Medicine. I understand that I am financially responsible for all charges not covered by my authorization.

HIPAA Privacy Notice

The signature below acknowledges receipt of a copy of Spine & Musculoskeletal Medicine's Notice of Privacy Practices.

Consent to Medical Treatment

I, knowing that I have (or_____ has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and x-rays and to such medical treatment by Dr. Devney and his assistants, or his designees as necessary in his judgment.

_____ _____

Signature of patient or person legally authorized to consent for patient Today's Date