Today's Date ____ /____ /____

Please complete and give to receptionist with your insurance cards.

PATIENT INFORMATION

Patient's Last Name / First / Middle	☐Mr ☐Mrs ☐Miss ☐Ms	Age	Birth Date / /	Sex M / F	Employer Name	Occupation

Street Address	City	State	Zip	Social Security #	Home Phone # ( )	Cell Phone # ( )

Referring Physician	Referring Physician Phone # ( )	Primary Care Physician	Primary Care Physician Phone # ( )

Pharmacy Name	Pharmacy Phone # ( )	Employer Phone # ( )

Emergency Contact Name	Relationship	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )

Power of Attorney Name if Applicable	Phone # ( )	Legal Document for P.O.A. Received Date / /

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST)

Primary Insurance	ID # (include prefix or suffix)	Group #	Plan #

Insurance Carrier Address	Relationship to Subscriber(ie. spouse, parent)

Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer

Secondary Insurance	ID # (include prefix or suffix)	Group #	Plan #

Insurance Carrier Address	Relationship to Subscriber(ie. spouse, parent)

Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer

WORKERS COMPENSATION INFORMATION if you have more than one active workers compensation claim please complete the information for each separately below

Date of Injury	Injury (body area covered)	Insurance Carrier Name	Employer

WCB #	Carrier Case #	Case Worker Name and Phone Number

Ins. Carrier Address	City	State	Zip	Apportionment %

Second Date of Injury	Injury (body area covered)	Insurance Carrier Name	Employer

WCB #	Carrier Case #	Case Worker Name and Phone Number

Ins. Carrier Address	City	State	Zip	Apportionment %

NO FAULT INFORMATION

Date of MVA	Insurance Carrier Name	No Fault Claim #

Ins. Carrier Address	City	State	Zip

Adjuster Name and Number

I authorize release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to the NY Spine & Wellness Center for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above named patient. Failure to give 24 hour notice of cancellation of a NCS/EMG study or a procedure or no-showing for a NCS/EMG study or a procedure will result in a charge of $50.00 per occurrence. This charge cannot be billed to the insurance company. It will be my responsibility.

Patient/Relative/Guardian* Print Name Date/Time

Relationship to Patient

Interpreter (if required) Print Name Date/Time

Witness Print Name Date/Time

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.