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_____________