PATIENT REGISTRATION FORM

Do you currently have an active WORKER'S COMPENSATION claim? □ YES □ NO

Does your current condition result from a motor vehicle accident? □ YES □ NO

How did you hear about our practice? _____

PATIENT INFORMATION : Last Name: _____ First Name: _____

SSN:_____ Home Phone_____Work Phone: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____ Marital Status:_____

Employer: _____

EMERGENCY CONTACT:

Name: _____

Home Phone: _____ Work Phone: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

ASSIGNMENT OF MEDICAL BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I authorize Piper Spine Care, P.C. to release any medical information necessary to process insurance claims relating to the medical care provided by its doctors and/or their associates.I authorize payment of medical benefits to Piper Spine Care, P.C. for any medical care provided to me or to by dependent(s). I understand that I will be responsible for any balance not covered by my insurance carrier(s). A finance fee will be charged at a rate of 1.5% per month for any outstanding balance. Should my account be sent to an attorney for collection, I agree to pay attorney fees, costs, and collection expenses.

By my signature, I verify that the information on this form is true and correct as of the date indicated below:

_____ _____

Signature, Patient or Patient's Representative **Date**

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