Jefferson Headache and Spine

Patient's Full Name:_________________________ DOB __________ S.SEC #________

Guarantor Name ____________________________ DOB_________ S.SEC #_____________

Home Address:_____________________________ City:________________ State______ Zip:________

Mailing Address: ____________________________________ City:_________ State_____ Zip_______

Home Phone #:________________________ Cell Phone #: _____________ Work #: ________________

Marital Status: Single / Married / Divorced / Separated / Widowed Sex: Male / Female

Employer Name __________________________Address____

Is your condition a Workman's Compensation case Yes / No Authorization #____________________

Is your condition related to an accident Yes / No

Is there any open law suits pending relating to the accident? Yes / No

Emergency Contact: ______________________________ Emergency Contact #:____________________

Pharmacy Name & Phone Number:____

Primary Physician: _________________________ Referring Physician: ___________________________

How did you learn of our practice? ___________________________Email Address: ________________

Name of Insured:______________________DOB___________ Relationship to Patient_______________

Insurance Company ___________________ Policy #_______________Group #___________________

COPAY / DEDUCTIBLE PAYMENT DUE AT TIME OF SERVICE

CONSENT FOR SERVICES AND PAYMENT

I, the undersigned certify that I (or dependent) have insurance coverage with_______________ and we irrevocably assign directly to Jefferson Headache and Spine, LLC all insurance benefits, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information and the use of this signature on all claims to secure the benefit payments.

For all services not covered by Medicare or other insurances, I take full responsibility for all charges for services rendered. I understand and agree if insurance fails to settle claim in 30 days after date of service the account balance will become past due and I shall assume full responsibility of balances after 30 days wait on Insurance company.

Responsible Party Signature: ____Date: