

**ST. LOUIS SPINE CARE ALLIANCE
PATIENT INFORMATION**

SECTION 1: PATIENT

DATE: ____ / ____ / ____

This section refers to the PATIENT ONLY:

LEGAL NAME: _____
(Last) (First) (Middle) (Name you wish to be called)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

WORK PHONE: (____) _____ E-MAIL: _____

SEX: M F BRITHDATE: ____ / ____ / ____ SOCIAL SECURITY NUMBER: _____

EMPLOYED (circle one): YES NO DISABLED RETIRED STUDENT

PRESENT EMPLOYER NAME: _____

REFERRED BY: _____

MARITAL STATUS (circle one): SINGLE MARRIED DIVORCED WIDOW / WIDOWER

SPOUSE NAME: _____ SPOUSE WORK NUMBER: (____) _____

EMERGENCY CONTACT NAME: _____ NUMBER: (____) _____

EMERGENCY CONTACT RELATIONSHIP: _____

IS THIS A WORK RELATED INJURY: YES NO IF YES, DATE OF INJURY: ____ / ____ / ____

EMPLOYER AT TIME OF INJURY: _____

IS THIS AN AUTO ACCIDENT: YES NO IF YES, DATE OF ACCIDENT: ____ / ____ / ____

SECTION 2: GUARANTOR / SPOUSE / PARENT INFORMATION

LEGAL NAME: _____
(Last) (First) (Middle) (Name you wish to be called)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

WORK PHONE: (____) _____ E-MAIL: _____

SEX: M F BRITHDATE: ____ / ____ / ____ SOCIAL SECURITY NUMBER: _____

EMPLOYED (circle one): YES NO DISABLED RETIRED

PRESENT EMPLOYER NAME: _____

PLEASE COMPLETE THE BACK OF THIS FORM

CONFIDENTIALITY CLAUSE:

I authorize St. Louis Spine Care Alliance to release medical information within the network of the St. Louis Spine Care Alliance Physicians and to:

their relationship to me is _____

Patient / Parent / Spouse / Guarantor Signature Date

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I authorize the treating physician to furnish information to insurance carrier concerning my illness and treatments, and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Further, I understand I am responsible for payment on your account in full, if in three months from the date of service, my insurance company has not yet paid. I am also responsible regardless of any litigation.

Patient / Parent / Spouse / Guarantor Signature Date

SIGNATURE ON FILE FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made on my behalf to the treating physician(s) for any services furnished me by that physician(s); I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient / Parent / Spouse / Guarantor Signature Date

CO-PAYS ARE EXPECTED AT THE TIME OF THE OFFICE VISIT