InvisionHealth

Brain and Spine Center

PATIENT INFORMATION:

FIRST NAME	MI	LAST NAME	SS#	SEX M F	AGE	BIRTH DATE

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELLPHONE	EMAIL	PRIMARY LANGUAGE

RACE: ❑ WHITE ❑ BLACK/AFRICAN AMER. ❑ AMER. INDIAN/ALASKA NATIVE ❑ ASIAN ❑ NATIVE HAWIIAN/PACIFIC ISLANDER ❑ OTHER

ETHNICITY: ❑ SPANISH/HISPANIC ORIGIN ❑ NOT SPANISH/HISPANIC ORIGIN ❑ UNKNOWN

EMPLOYMENT STATUS:

❑ FULL TIME / ❑ PART TIME / ❑ UNEMPLOYED / ❑ RETIRED

IF EMPLOYED: EMPLOYER NAME

EMPLOYER ADDRESS	CITY	STATE	ZIP

EMPLOYER PHONE	POSITION

EMERGENCY CONTACT INFORMATION:

FIRST NAME	MI	LAST NAME	RELATIONSHIP TO PATIENT

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELLPHONE	EMAIL

PRIMARY CARE PHYSICIAN:

FIRST NAME	LAST NAME	

STREET ADDRESS	CITY	STATE	ZIP

PHONE	FAX NUMBER

REFERRING PHYSICIAN:

FIRST NAME	LAST NAME	SPECIALTY

STREET ADDRESS	CITY	STATE	ZIP	

PHONE	FAX NUMBER

My primary decision to schedule an appointment was influenced by (check all that apply): ❑ REFERRING PHYSICIAN ❑ PRIMARY CARE PHYSICIAN ❑ ANOTHER PATIENT ❑ FRIEND ❑ FAMILY ❑ ONLINE SEARCH ❑ NEWSPAPER ❑ RADIO ❑ TV ❑ OTHER _____

Print Name_____ **Signature**_____ **Date**_____

PRIMARY MEDICAL INSURANCE:

INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

SECONDARY MEDICAL INSURANCE:

INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
MEMBER ID #	GROUP #	EFFECTIVE DATES	
NAME OF POLICY HOLDER	BIRTH DATE	SSN#	RELATIONSHIP TO PATIENT

WORKERS COMPENSATION OR NO FAULT INSURANCE INFORMATION:

IS THIS A WORK RELATED INJURY? **YES** **NO** (PLEASE CIRCLE)	DATE OF INJURY
IS THIS AN AUTOMOBILE INJURY? **YES** **NO** (PLEASE CIRCLE)	DATE OF INJURY
IF YOU CIRCLED YES TO EITHER OF THE ABOVE PLEASE COMPLETE:	
IS THIS AN OPEN CASE? **YES** **NO** (PLEASE CIRCLE)	NAME OF YOUR ATTORNEY

WORKERS COMPENSATION OR NO FAULT INSURANCE CARRIER NAME			
ADDRESS	CITY	STATE	ZIP
CLAIM # / WORKERS COMP BOARD #	CARRIER #		
CLAIM REPRESENTATIVE	PHONE		
EMPLOYER AT TIME OF INJURY			
ADDRESS	CITY	STATE	ZIP

AGREEMENT AND ACKNOWLEDGEMENT

I understand and agree that as part of my treatment plan, it may become necessary to disclose my protected health information to other entities to assist with my medical care and billing. I consent to such disclosure. In the event that my insurer determines the service is "not covered" by the terms of my health care plan, I accept responsibility for payment in full.

Print Name_____ Signature_____ Date_____

Please list family and friends involved in your medical care and/or payment of your medical bills to whom you authorize Brain and Spine Medical Services, PLLC to speak with and to disclose information to.

Name_____ Name_____

Name_____ Name_____