

The Advanced Spine Center

Jason Lowenstein, M.D.

Jamie DiGraziano, PA-C

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX			CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE		SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> CU
EMAIL ADDRESS	PHONE # TO BEST CONTACT YOU: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other			
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	
				NAME OF CUSTODIAL PARENT	
RACE	ETHNICITY <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Not Reported/Refused		LANGUAGE		

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #	
STREET ADDRESS/ P.O. BOX			CITY	STATE	ZIP
EMAIL ADDRESS	HOME PHONE	WORK PHONE		CELL PHONE	
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other		CO-PAY AMOUNT

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:
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IS THIS INJURY/ACCIDENT RELATED TO: <input type="checkbox"/> WORK <input type="checkbox"/> MOTOR VEHICLE <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Advanced Spinal Care & Associates, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient's representative

Date