SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
4590 Premier Drive • High Point, NC 27265
Phone: (336) 333-6306 • Fax: (336) 333-6309

Patient Information

Use Black Ink Only!

Account #:	**E-mail:**	**Doctor:**
Patient Last Name	First Name	Middle/Maiden Name
Patient Address Street	City	State Zip
Patient Home Phone #	Patient Work Phone #	Employer:
(Please Circle) Male Female	Date of Birth:	Social Security #:
Preferred Language:		**Ethnicity (Please Circle)** Hispanic Not Hispanic

Race (Please Circle)
American Indian Alaska Native Asian Black Native Hawaiian White Refuse to answer Do not know

Marital Status? (Please Circle) Single Married Separated Widower Widow	Known Allergies:

Responsible Party's Last Name	First Name	Middle/Maiden Name
Responsible Party's Address Street	City	State Zip
Responsible Party's Home Phone #	Responsible Party's Work Phone #	E-mail address:
(Please Circle) Male Female	Date of Birth:	Social Security #:

***Medicare Patients Only* Was this a liability injury? (Please Circle) Yes No If yes, please ask receptionist for additional form.**

Were you hurt at work? (Please Circle) Yes No
If yes, have you notified your employer? Yes No Did your employer file an injury report with their Workers Compensation carrier? Yes No
Who is the person to contact at your employer? Name: Phone #:

When did problem start or was it result of accident?

Onset Date _____ **Auto Accident Date** _____

Accident Date _____ **Workers Comp Accident** _____

Primary Insurance:	Policy Holder's Name:	Policy #:
Policy Holder's SS #:	Policy Holder's Date of Birth:	Group #:
How is the patient related to Policy Holder? (Please Circle) Self Husband Wife Male Child Female Child		Effective Date:
Policy Holder's Employer:		Employer's Phone #:

Secondary Insurance:	Policy Holder's Name:	Policy #:
Policy Holder's SS #:	Policy Holder's Date of Birth:	Group #:
How is the patient related to Policy Holder? (Please Circle) Self Husband Wife Male Child Female Child		Effective Date:
Policy Holder's Employer:		Employer's Phone #:

Preferred Pharmacy Name & Location:	Pharmacy Phone #:	
Spouse's Name:	Daytime Phone #:	
Emergency contact (Not living with you)	Daytime Phone #:	Home Phone #:

Referred by (Please Circle) Another Doctor: _____ Family/Friend TV Radio Website
ER Cone ER Wesley Long Yellow Pages Newspaper Insurance Company Employer Other:

SIGNATURE (PATIENT, PARENT OR RESPONSIBLE PARTY) **DATE**