# 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

| **Account #:** | **Primary Care Physician:** | **Referred By:** |
|---|---|---|
| Patient Last Name | First Name | Middle/Maiden Name |
| Patient Address Street | City | State Zip |
| Cell Phone # | Home Phone # | Employer: Work # |
| (Please Circle) Male Female | Date of Birth: | Social Security #: |
| Email: | 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 Mixed

| **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: | Phone #: | |
| Emergency contact (Not living with you) | Phone #: | Relationship: |

## CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

Our office may contact you via phone call, letter, email, and/or text messaging to remind you of an appointment and to provide general health reminders/information. By providing the practice with your e-mail address, cellular and/or landline phone number, you are agreeing to be contacted by phone, e-mail and/or text message.

## PERMISSION TO RELEASE MEDICAL AND BILLING INFORMAITON:

May we discuss your health/billing information with your: Spouse: Yes/No Parent: Yes/No Other named below:

I authorize Spine & Scoliosis Specialists to release information concerning my treatment(s) including prescriptions to:

| | |
|---|---|
| (Name) | (Relationship to Patient) |
| (Name) | (Relationship to Patient) |
| (Name) | (Relationship to Patient) |

BY SIGNING BELOW, PATIENT/GUARDIAN CONSENTS TO RECEIVE TEXTS, CALLS, AND/OR EMAIL FOR APPOINTMENT REMINDERS AND OTHER HEALTH CARE COMMUNICATIONS.

| | | |
|---|---|---|
| **Signature of Patient or Responsible Party** | **Relationship if Not Patient** | **Date** |