



SPURLOCK SPINE CENTRE

Registration

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.

PLEASE PRINT

Full Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS# _____ Driver's License # _____ State of Issue: _____

Preferred or Prior Name: _____ E-mail Address: _____

Marital Status (circle none): S M W D Sep Gender: M F No. of Children: _____

Employment Status: Employed Part-time student Full-time student Retired Unemployed
 Homemaker Other

Occupation: _____ Employer: _____ Years on Job: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Birthdate: _____ SS# _____

Spouse's Occupation: _____ Employer: _____ Work Phone: _____

Relative to Contact in Case of Emergency (not living in home):

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have health insurance: No Yes Insurance Company: _____

Name of Insured: _____ Birthdate: _____ Relationship to patient: _____

Identification Number: _____ Group Number: _____

Does your spouse have insurance at work? No Yes Insurance Company: _____

How did you find out about our office? _____

Is your condition due to an accident or work-related injury? No Yes Date of Injury: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photocopy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photocopy of this agreement shall serve as the original.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits. Completing disability insurance forms may also require an additional fee.

Payment Options (Please Indicate): Cash Check Mastercard Visa Discover American Express