SOUTHEASTERN
SPINE & NEUROSURGERY

DATE:_____

NAME: (F) (M) (L)

DATE OF BIRTH: SEX: RACE:

SOCIAL SECURITY NUMBER: MARITAL STATUS:

ADDRESS: CITY: STATE: ZIP:

EMPLOYER: ADDRESS: CITY:

STATE: ZIP: PHONE: EXT.

CONTACT INFORMATION:

HOME PHONE: WORK PHONE: MOBILE:

EMAIL ADDRESS:

EMERGENCY CONTACT PERSON NAME: RELATIONSHIP:

EMERGENCY CONTACT ADDRESS: CITY:

STATE: ZIP: PHONE:

Workers Compensation/Accident Information: **State of MVA, Accident or Injury:_____**

Date of injury or accident:_____ Was injury due to: (circle one) **Auto Accident: Yes No Workers Comp: Yes No**

Carrier Name: Attorney Name:

Case Manager/Adjuster: Attorney Address:

Claims Address: City, State, Zip:

Phone #: Phone #:

Claim #: Employer at time of injury:

Authorization: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date: