SOUTHEASTERN
SPINE & NEUROSURGERY

Date: _____

Name: (First) (Middle) (Last)

Date of Birth: Sex: Race:

Social Security Number: Marital Status:

Address City: State: Zip Code:

Employer: Address: City: State: Zip Code:

Phone: Extension:

Contact Information:

Home phone: Work phone: Mobile:

Email address:

Emergency Contact Person: Phone: Relationship:

Insurance Information:

Primary Plan:	Secondary Plan:
Group/Employer:	Group/Employer:
Insured Name:	Insured Name:
Insured DOB:	Insured DOB:
Relation to Patient: Copay: $	Relation to Patient: Copay: $

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, attorney's fees, court costs, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date: