Chattanooga Neurosurgery & Spine

PATIENT INFORMATION
(PLEASE PRINT)
THIS FORM MUST BE COMPLETELY FILLED OUT

DO NOT OMIT ANY REQUESTED INFORMATION

DATE_____

PROVIDER BEING SEEN

_____

PATIENT

Name_____Age_____ DOB_____SS #_____
(first) (middle) (last)

Address_____City/State/Zip_____

Mailing Address_____City/State/Zip _____

Phone Numbers: Home (___)_____ Cell (___)_____ Email _____
(Circle preferred contact phone number)

Employer_____ Work (___) _____Occupation_____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

SPOUSE ☐ **GUARDIAN** ☐

Name_____Age_____ DOB_____SS #_____
(first) (middle) (last)

Address_____City/State/Zip_____
(if different than patient's)

Phone Numbers: Home (___)_____ Cell (___)_____ Email _____

Employer_____ Work (___) _____Occupation_____

EMERGENCY CONTACT (someone outside the home)

Name_____Phone (___)_____Relation_____

ACCIDENT- Work Related ☐ Other ☐ Date Of Accident _____
*If accident is work related there will be additional paperwork to fill out. Prior approval is required.

INSURANCE

PRIMARY INS._____Group #_____ID #_____

Policy Holder Name _____ DOB_____ SS #_____

SECONDARY INS._____Group #_____ID #_____

Policy Holder Name _____ DOB_____ SS #_____

REFERRED BY- Doctor ☐ Relative ☐ Friend ☐ Name_____

PRIMARY CARE PHYSICIAN

Name_____ Phone (___)_____

Address_____ City/State/Zip _____

PHARMACY

Name_____ Location _____ Phone (___) _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS

I hereby authorize Chattanooga Neurosurgery & Spine (The Neurosurgical Group of Chattanooga, P.C.) to release any information to the insurance company covering my procedures or any service rendered. I also authorize direct payment to Chattanooga Neurosurgery & Spine (The Neurosurgical Group of Chattanooga, P.C.) by the insurance company of any payments due. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

SIGNED_____ revised 6-2-14