REGISTRATION FORM
(Please Print)

Today's Date:	Primary Physician:	Referring Physician:

PATIENT INFORMATION

Full Legal Name	Sex ❑ M ❑ F	D.O.B.
Marital Status ❑ Single ❑ Married ❑ Divorce ❑ Widowed	Social Security No.	
Race ❑ White ❑ American Indian/Alaskan Native ❑ Black or African American ❑ Native Hawaiian/Pacific Islander ❑ Asian ❑ Some other race		

Home Phone ( )	Cell Phone ( )	Work Phone ( )	Email

Address	City	State	Zip

Emergency Contact	Phone #	Relationship to Patient

Employer's Name	Employer's Address	Employer's Phone #

How did you hear about Innovative Spine & Orthopedic Clinic?
❑ Family ❑ Friend ❑ Internet ❑ Physician ❑ Insurance ❑ Other

BILLING ADDRESSEE INFORMATION

Billing addressee is the person you authorize to receive your monthly billing statements and to coordinate billing and payment. If you will be considered your own Billing Addressee, you can proceed to "Insurance Information."

Guarantor:	Address (if different):		Relationship to Patient
Birth Date (mm/dd/yyyy)	Social Security No.	Home Phone No. ( )	Cell Phone No. ( )
Employer:	Employer Address		Employer phone #

INSURANCE INFORMATION (To be completed by ALL patients)

	Primary Insurance Information	**Secondary Insurance**
Insurance Company Name		
Policy Holder Name		
Policy Holder's Date of Birth		
Policy Holder's S.S. #		
Group No.		
Policy No./Member ID		
Patient's relationship to policy holder	❑ Self ❑ Spouse ❑ Child	❑ Self ❑ Spouse ❑ Child
Is the insurance through	❑ Employer ❑ Obamacare/Marketplace Plan	❑ Employer ❑ Obamacare/Marketplace Plan

ACCIDENT RELATED INFORMATION		
Is this a **motor vehicle accident**? ❑ Yes ❑ No	A **work injury**? ❑ Yes ❑ No	**Other:**
Date of Accident or Injury:	State Accident Occurred In:	
Claim#		
Adjustor Name:	Phone#	
Case Manager Name:	Phone#	
Attorney Name:	Phone#	

The above information is true to the best of my knowledge. I request payment of insurance benefits for all services rendered to me to be made on my behalf to Innovative Spine & Orthopedic Clinic. I authorize Innovative Spine & Orthopedic Clinic or insurance company to release any information required to process my claims. I also understand that I am financially responsible for any balance, which may include annual deductibles, co payments, co-insurances and charges, denied by my insurance.

_____ _____

Patient/Guardian Signature *Date*