

DEER VALLEY SPINE CENTER

Patient Registration

	Dr _____	Date _____	Time _____	Chart# _____	
PATIENT INFORMATION	NAME: LAST FIRST MIDDLE		BIRTHDATE	AGE	SSN
	STREET ADDRESS		HOME PHONE		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	CITY STATE ZIP		WORK PHONE		MARITAL STATUS
	EMPLOYER		REFERRING PHYSICIAN		
	ADDRESS		ADDRESS		
	CITY STATE ZIP		FAMILY PHYSICIAN		
	X-RAYS <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAYS WITH PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAY DATE		SEND LETTERS <input type="checkbox"/> Y <input type="checkbox"/> N
	X-RAY TAKEN AT	ALLERGIES OR MEDICAL CONDITIONS		REASON FOR SEEING DOCTOR	
	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT DATE	ACCIDENT OCCURRED <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER		ATTORNEY INVOLVED <input type="checkbox"/> YES <input type="checkbox"/> NO
	IF YES, ATTORNEY'S NAME AND PHONE NUMBER				
RESPONSIBLE PARTY	NAME: LAST FIRST MIDDLE		EMPLOYER		
	STREET ADDRESS		STREET ADDRESS		
	CITY STATE ZIP		CITY STATE ZIP		
	RELATION TO PATIENT		WORK PHONE		
	HOME PHONE	MUST COMPLETE IN CASE OF EMERGENCY (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU)			
	SSN	PHONE	RELATIONSHIP		
INSURANCE	INSURANCE (PLEASE CHECK ONE) <input type="checkbox"/> No Coverage <input type="checkbox"/> Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> CHAMPUS <input type="checkbox"/> PPO <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other				
	PRIMARY COMPANY		SECONDARY COMPANY		
	ADDRESS		ADDRESS		
	CITY STATE ZIP		CITY STATE ZIP		
	SUBSCRIBER'S NAME		SUBSCRIBER'S NAME		
	POLICY #		POLICY #		
	ID #	GROUP #	ID #	GROUP #	
	RELATION TO PATIENT		RELATION TO PATIENT		
	RELEASE OF MEDICAL INFORMATION				
	<p>AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Deer Valley Spine Center, for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Deer Valley Spine Center for those services.</p> <p>INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Deer Valley Spine Center to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.</p> <p>FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage.</p>				
PATIENT SIGNATURE _____			DATE _____		
INSURED'S SIGNATURE (If other than patient) _____			DATE _____		