The Spine and Brain Institute

Patient Information Form

Today's Date: _____

I am seeing (circle one): Dr. Duke Dr. Forage Dr. Anson Dr. Seiff

Date: _____ **Referring Doctor's Name:** _____
FIRST LAST

Patient's Name: _____
FIRST MIDDLE LAST

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Email Address: _____ May we send information here? ☐ Yes ☐ No

Employer: _____ **Occupation:** _____

Employer's Address: _____ **Work Phone:** (_____) _____

City: _____ **State:** _____ **Zip code:** _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ White/Caucasian
☐ Hispanic ☐ Pacific Islander ☐ Other ☐ Do not wish to provide

Primary Language: ☐ English ☐ Spanish ☐ Other _____

GUARDIAN/PARENT INFORMATION (financially responsible, if other than patient)

Name: _____
FIRST MIDDLE LAST

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____

Relationship to patient?: _____

Employer: _____ **Occupation:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip code:** _____

INCASE OF EMERGENCY CONTACT INFO

Name: _____ **Relationship to patient?** _____

Home Phone: (_____) _____ **Work Phone:** (_____) _____

Derek A. Duke, M.D., F.A.C.S., James S. Forage, M.D., F.A.C.S., John A. Anson, M.D., F.A.C.S., Michael E. Seiff, M.D., F.A.C.S.,

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Patient's Name: _____
FIRST MIDDLE LAST

INSURANCE INFORMATION

We will need your current insurance card and your driver's/form of identification.

Are you being seen due to an Accident or Injury? ☐ Yes ☐ No Is Yes, Date of Accident/Injury:_____

Type of Accident: ☐ Work Related ☐ Auto ☐ Other _____

Primary Insurance/Auto Insurance/ Workers' Compensation Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

Secondary Insurance or Attorney Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

All professional services rendered are charged to the patient. ***The patient is responsible for all fees, regardless of insurance coverage.*** *In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to Drs .Duke, Forage, Anson, and Seiff.*

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any surgical or medical benefits under claims submitted directly to Derek A. Duke, M.D, James S. Forage, M.D., John A. Anson, M.D., and Michael E. Seiff, M.D. I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Signature of patient or responsible party: _____ **Date:** _____

SBI Staff Signature: _____ **Date:** _____

For internal use only: Patient present with ID and/or insurance card(s) Yes No

If no, reason card(s) are not presented _____

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