

# Piedmont Spine Specialists

## Registration Form

Chart # \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: M S W D SEP

Address: \_\_\_\_\_  
(Street)

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
(City) (Zip)

Family Physician: \_\_\_\_\_

Referred by: Dr. \_\_\_\_\_  
(First) (Last)

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Zip \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street) (City) (Zip)

Emergency Contact: \_\_\_\_\_ Contact's Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

\*\*\*\*\*INSURANCE INFORMATION\*\*\*\*\*

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Effective Date: \_\_\_\_\_

\*\*\*\*\*PAYMENT AGREEMENT\*\*\*\*\*

I hereby authorize my insurance company to pay any benefits due directly to PIEDMONT SPINE SPECIALISTS. I also understand and agree that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate my account, I shall be personally liable for the unpaid balance of the account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICARE/MEDICAID AUTHORIZATION

I request that payment of authorized Medicare or Medicaid benefits be made either to me or on my behalf to PIEDMONT SPINE SPECIALISTS for any services furnished to me by PIEDMONT SPINE SPECIALISTS. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_