subach
spinal solutions

PATIENT REGISTRATION FORM

DATE:_____

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____
Date of birth: _____ SSN:_____ Male☐ Female☐
Employer:_____ Occupation:_____
Marital Status: S☐ M☐ D☐ W☐ Spouse/Partners Name:_____
Mailing Address:_____
City:_____ State:_____ Zip:_____
Physical Address (if different from above):_____
City:_____ State:_____ Zip:_____
Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____
Email Address:_____
Preferred Method of Communication: Home Phone☐ Cell Phone☐ Email☐ Patient Portal☐

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone#:_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy Holder:_____
Relationship:_____ Policy holder SSN:_____ Policy holder DOB:_____
Policy holder Employer:_____ Member ID#:_____
Group #:_____
Is this Worker's Compensation? YES☐ NO☐ *If yes, provide claim information at time of check-in*

Secondary Insurance:_____ Policy Holder:_____
Relationship:_____ Policy holder SSN:_____ Policy holder DOB:_____
Policy holder Employer:_____ Member ID#:_____
Group #:_____

BILLING INFORMATION

Person Responsible for Bill:_____ Relationship:_____
Contact Phone#:_____

How did you hear about us?

☐PCP/Referring Provider/Insurance
☐Previous/Existing Patient
☐Coworker/Family/Friend
☐Magazine/Newspaper
☐Social Media/Website