

**SPINE AND ORTHOPEDIC CENTER OF NEW JERSEY, LLC**  
**90 SPARTA AVE, SPARTA, NJ 07871 PHONE (973) 726-9500 FAX (973) 726-8218**

**PATIENT INFORMATION**

**PATIENT'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SEX:** M / F **SS#:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_ **TOWN:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_  
**HOME PHONE #:** \_\_\_\_\_ **WORK #:** \_\_\_\_\_ **CELL #:** \_\_\_\_\_

**SPOUSE/PARENT(S) NAME:** \_\_\_\_\_ **PHONE NO.:** \_\_\_\_\_  
**EMERGENCY CONTACT: NAME** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_  
**TELEPHONE: HOME** \_\_\_\_\_ **WORK** \_\_\_\_\_ **CELL** \_\_\_\_\_  
**PATIENT'S E-MAIL ADDRESS:** \_\_\_\_\_

**INSURED'S EMPLOYER:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_  
**EMPLOYER ADDRESS:** \_\_\_\_\_ **TELEPHONE#:** \_\_\_\_\_  
**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_

\*\*\*\*\*

**MUST BE FILLED IN IF AN MVA CASE**

**YOUR MVA INSURANCE INFORMATION**

**INSURANCE NAME:** \_\_\_\_\_  
**INS. PHONE #:** \_\_\_\_\_  
**ADJ. NAME:** \_\_\_\_\_  
**ADJ. PH#:** \_\_\_\_\_  
**CLAIM#:** \_\_\_\_\_

**OTHER PARTY MVA INSURANCE INFORMATION**

**INSURANCE NAME:** \_\_\_\_\_  
**INS. PHONE #:** \_\_\_\_\_  
**ADJ. NAME:** \_\_\_\_\_  
**ADJ. PH#:** \_\_\_\_\_  
**CLAIM#:** \_\_\_\_\_

\*\*\*\*\*

**PRIVATE INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY NAME:** \_\_\_\_\_  
**POLICY HOLDERS' NAME:** \_\_\_\_\_ **ID#:** \_\_\_\_\_  
**INSURED'S SS #** \_\_\_\_-\_\_\_\_-\_\_\_\_ **INSURED'S DOB** \_\_\_\_\_

**SECONDARY INSURANCE COMPANY NAME:** \_\_\_\_\_  
**POLICY HOLDERS' NAME:** \_\_\_\_\_ **ID#:** \_\_\_\_\_  
**INSURED'S SS #** \_\_\_\_-\_\_\_\_-\_\_\_\_ **INSURED'S DOB** \_\_\_\_\_

\*\*\*\*\*

**DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES?**

**ARTHRITIS    GOUT    DIABETES    ULCERS    HIGH BLOOD PRESSURE    HEART CONDITION**

**ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN: YES** \_\_\_\_ **NO** \_\_\_\_

**REFERRED BY: ( ) FRIEND    ( ) DOCTOR** \_\_\_\_\_ **( ) YELLOW PAGES    ( ) OTHER**

\*\*\*\*\*

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE OR INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I ASSIGN TO DR. BASCH ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT, FOR SERVICES RENDERED TO ME BY DR. BASCH. I AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO MY CLAIMS BY DR. BASCH TO BE RELEASED TO DR. BASCH. I AUTHORIZE DR. BASCH TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO DR. BASCH.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SPINE AND ORTHOPEDIC CENTER OF NEW JERSEY, LLC**  
**90 SPARTA AVE, SPARTA, NJ 07871 PHONE (973) 726-9500 FAX (973) 726-8218**

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_  
SPOUSE/PARENT(S) NAME: \_\_\_\_\_  
EMERGENCY CONTACT: NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

**INSURANCE INFORMATION**

INSURED EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_ TELEPHONE#: \_\_\_\_\_  
**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **ADDRESS:** \_\_\_\_\_  
**PRIMARY INSURANCE COMPANY NAME:** \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_  
ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_ COPAY AMOUNT: \$ \_\_\_\_\_  
INSURED'S SS # \_\_\_\_-\_\_\_\_-\_\_\_\_ INSURED'S DOB \_\_\_\_\_ REFERRAL: YES \_\_\_\_ NO \_\_\_\_

**SECONDARY INSURANCE COMPANY NAME:** \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_  
ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ COPAY AMOUNT: \$ \_\_\_\_\_  
INSURED'S SS # \_\_\_\_-\_\_\_\_-\_\_\_\_ INSURED'S DOB \_\_\_\_\_ REFERRAL: YES \_\_\_\_ NO \_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE OR INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I ASSIGN TO DR. BASCH ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT, FOR SERVICES RENDERED TO ME BY DR. BASCH. I AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO MY CLAIMS BY DR. BASCH TO BE RELEASED TO DR. BASCH. I AUTHORIZE DR. BASCH TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO DR. BASCH.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_