

PATIENT INFORMATION

PATIENT NAME: _____ SEX: MALE ___ FEMALE ___ AGE: ___
MAILING ADDRESS: _____ BIRTH DATE: _____
TOWN: _____ STATE: _____ ZIP CODE: _____
TELEPHONE- HOME: _____ WORK: _____ CELL: _____
SOCIAL SECURITY: ___ - ___ - ___ MARITAL STATUS: M ___ S ___ D ___ W ___ MINOR ___
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: _____

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

REASON FOR VISIT:

PLEASE LIST ALL YOUR MEDICATIONS AND THEIR DOSAGES:

ALLERGIES TO MEDICATIONS:

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS OR ORTHOPEDIC PROBLEMS? PLEASE GIVE DATES: _____

DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES? PLEASE CHECK AND GIVE DATE OF ONSET:

ARTHRITIS: _____ DATE: _____ GOUT : _____ DATE: _____

DIABETES : _____ DATE: _____ ULCERS: _____ DATE: _____

HIGH BLOOD PRESSURE: _____ DATE: _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN: YES _____ NO _____

REFERRED BY: () FRIEND _____
() DOCTOR _____
() YELLOW PAGES _____
() OTHER _____