Account #: ______________________ Drivers License #: ______________________

First Name: ______________________ Middle Initial: _____ Last Name: ______________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: (________)________-______________ Cell Phone: (________)________-______________

DOB: ______________________ mm/dd/yyyy Social Security #: ______________________

Who Referred You? ____

Age: ____________ Check: Male Female Single Married Divorced Separated Widowed

Employer: ______________________ Employer Phone: (______)_______-__________

Address: ______________________ City: ______________ State: _____ Zip: __________

Occupation: ______________________ Job Title: ______________________

Name of Spouse/Significant Other: ______________________ Phone: (______)_______-__________

Education (highest level completed): ______________ Primary Care Physician: ______________________

Health Insurance Information:

Primary Carrier: ______________________ Subscriber: ______________________

ID#: ______________ Group #: ______________ Relation to patient: ______________

Subscriber SSN: ______________________ Subscriber DOB: ______________________

Secondary Carrier: ______________________ Subscriber: ______________________

ID#: ______________ Group #: ______________ Relation to patient: ______________

Emergency Contact: ______________________ Phone: (______)_______-__________

Insurance Authorization: I hereby authorize San Antonio Spine Center to furnish information to my insurance carriers concerning my illness and treatment.

Assignment of Benefits: I hereby assign to San Antonio Spine Center all payments for medical services rendered to my dependents or myself. I understand that I am responsible for my amount not covered by my insurance within 30 days of the statement date. Co-payment is expected at the time services are rendered.

Signature: ____ Date: ______________________

SAN ANTONIO
SPINE CENTER
KEVIN RICHARDSON, D.O.