

**PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Zip: \_\_\_\_\_ Sex: \_\_\_\_\_ Soc Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Email address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EMERGENCY contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

Party responsible for account (If Work Comp or Auto provide that information)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB \_\_\_\_\_

Responsible person's employer: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Address to Mail Claim:

Additional Insurance

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Attorney's name (if applicable) \_\_\_\_\_ Phone: \_\_\_\_\_

Major credit card type and number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopaedic & Spine Center, P.C. (NOSC) and Non Surgical Orthopaedic Pain Center, P. C. (NOPC) to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I acknowledge that I understand by the policies of the practice of NOSC as read in the Practice Handbook, and will be bound by the provisions contained in the Handbook. I also authorize the practice to release any medical information or insurance information that requested by any physical therapy, diagnostic imaging or clinical research facility that the practice refers me to as part of my treatment.

Patient (Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_