ATLANTA SPINE INSTITUTE

Patient Name: ____Date:____________ Sex: M___F___
Last First Middle

Address:____
Street Apartment/Lot#

____
City State Zip County

Telephone#: Home________________ Cell_________________ Alternative____________________

Email Address: __________________________________ Fax #: ________________________

Marital Status:_________ Birthdate:____________ Age:_____ Social Security#:________________

Patient Employer:_____________________________________Occupation:____________________

Employer Address:____________________________________Telephone#:____________________

Parent or Spouse: _____________________________________Social Security#:_________________

Parent or Spouse Employer:______________________________Occupation:___________________

Address:____Telephone#:_____________________

Name, Address & Telephone Number of relative or friend who does not live in your household:______________

____

Who referred you to us? ______________________________ Telephone#:_______________________

Address of referring doctor: ____

Have you been treated elsewhere? _______ If so, by whom?______________________________________

Family doctor: ____Telephone#:______________________

Present Medications:____

____

Drug Allergies:____

Patient Name:____

Description of Problem/Injury: ____

Neck:_____________________ Upper Back:________________________ Lower Back:___________________

Is this problem work-related? Yes:_____ No:____ Sports Related? Yes:___ No:____ Other:_______________

If work or sports-related, what is the date of the injury?____

If other, please give approximate date of onset of pain/injury:____

Other medical problems:____

____

Primary Insurance Carrier
____

Policy Number:___________________________
Group Number:___________________________
Policy Holder:____________________________

Secondary Insurance Carrier
____

Policy Number:____________________
Group Number:____________________
Policy Holder:_____________________

**All professional services rendered are charged to the patient. All necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office or accounts managers.

**I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to ATLANTA SPINE INSTITUTE or any services furnished to me by that party who accepts assignment/ physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize ATLANTA SPINE INSTITUTE to release to the Social Security Administration and Health Care Financing Administration or its intermediaries carrier or any other insurance company information needed for this related to Medicare/other insurance company claim. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay this claim.

Signature: ____Date:___________________

CONSENT FOR THE USE AND DISCLOSURE OF PROTECED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Plas T. James, M.D./Atlanta Spine Institute, our staff, and our business associates for treatment, payment, and healthcare operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Privacy Practices ("Notice").

You have the right to request that we restrict our uses or disclosures of your protected health Information; which we are the otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

Signature:____

Date:____