SBI
THE SPINE & BRAIN
INSTITUTE

Patient Information Form

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.,
James S. Forage, M.D. ▪ Angela W. Palmer, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

Date: _____ I am seeing: ☐ Dr. Anson ☐ Dr. Cox ☐ Dr. Duke ☐ Dr. Forage ☐ Dr. Palmer ☐ Dr. Seiff ☐ Dr. Yi

Referring Doctor's Name: _____

Patient's Full Name: _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: (_____) _____ **Cell #:** (_____) _____

Email Address: _____ May we send information here? ☐ Yes ☐ No

Employer: _____ **Employer#** (_____) _____

Employer's Address: _____

City: _____ **State:** _____ **Zip code:** _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ White/Caucasian ☐ Hispanic ☐ Pacific Islander ☐ Other ☐ Do not wish to provide

Primary Language: ☐English ☐Spanish ☐ Other:_____

Guardian/Parent (financially responsible, if other than patient)

Name: _____ **Relation to patient:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Social Security #:** _____

Home #: (_____) _____ **Cell #:** (_____) _____

Employer: _____ **Employer#** (_____) _____

Employer's Address: _____

City: _____ **State:** _____ **Zip code:** _____

Emergency Contact

Name: _____ **Relation to patient?** _____

Home #: (_____) _____ **Cell #:** (_____) _____ **Work#:** (_____) _____

Patient's Name: _____ **DOB:** _____

Insurance Information

Please provide insurance card and your driver's license

Are you being seen due to an accident or injury? ☐ Yes ☐ No If Yes, date of accident/injury:_____

Type of Accident: ☐ Work Related ☐ Auto ☐ Other: _____

Primary Insurance/Auto Insurance/Workers' Compensation Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

Secondary Insurance or Attorney Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

All professional services rendered are charged to the patient. ***The patient is responsible for all fees, regardless of insurance coverage.*** *In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to The Spine and Brain Institute and/or Dr. Duke, Dr. Forage, Dr. Anson, Dr. Seiff, Dr. Cox, Dr. Palmer.*

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any surgical or medical benefits under claims submitted directly to The Spine and Brain Institute and/or John A. Anson, M.D., Efrem M. Cox, M.D., Derek A. Duke, M.D, James S. Forage, M.D., Angela W. Palmer, M.D, Michael E. Seiff, M.D., Julia Yi, M.D. I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Signature Patient/Responsible Party: _____ **Date:** _____

SBI Staff Signature: _____ **Date:** _____

For internal use only: Patient present with ID and/or insurance card(s)? ☐ Yes ☐ No

If no, reason card(s) are not presented _____