SPECIALTY CLINICS
SPINE INTERVENTION, PC

www.scgpain.com

Account # _____
Physician: _____
Date:_____

The American Recovery and Reinvestment Act of 2009 requires that we gather additional information from you. Thank you for answering the following three questions:

1. Race:

American Indian or Alaska Native Black, African American Native Hawaiian, Other Pacific Islander Asian White
Unknown Declined

2. Ethnicity:

Hispanic or Latino Non-Hispanic or Non-Latino Declined Unknown

3. Primary Language:

English Spanish Other: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Goes By: _____

DOB: _____ SSN: _____ Gender: Male Female Marital Status _____ Spouse's Name: _____

Home Address: _____

Billing Address: (if different) : _____

City: _____ State: _____ ZIP: _____ Email address: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

How would you prefer we contact you for appointment reminders, etc.? Home Phone Cell Phone Text Message Email

Employer Name: _____Phone#: ( ) _____-_____

Emergency Contact: _____ Phone: ( ) _____-_____ Relationship to Patient: _____

INSURANCE INFORMATION

***Please provide insurance card and picture I. D. to receptionist.**

Primary Subscriber: (if different than patient): _____Relationship to Patient: _____

Subscriber's DOB: _____

PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT (if other than patient)

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____/____/_____ Relationship to Patient: _____ Phone#: ( ) _____-_____

REFERRING PHYSICIAN:

Who may we thank for referring you to our office? _____

Who is your Primary Care Physician (PCP)?_____