(PLEASE COMPLETE ENTIRE FORM)

PATIENT NAME: ____

DATE OF BIRTH: ______________________ SSN: ___________________________

ADDRESS: ____

CITY, STATE, ZIP: ____

PHONE: _______________________ CELL PHONE: ________________________

EMPLOYER: ___________________________WORK PHONE ___________________

ARE YOU PARTICIPATING IN WORKMAN'S COMPENSATION? **YES_____ NO_____**

IF SO, NAME AND ADDRESS OF EMPLOYER: ______________________________

_______________________________________DATE OF ACCIDENT_______________

CASE WORKER: ______________________________ PHONE: ___________________

IS YOUR INSURANCE UNDER SPOUSE'S/PARENT'S? **YES_____ NO_____**

IF YES, SPOUSE'S / PARENT'S SSN______________________________________

IF YES, SPOUSE'S / PARENT'S DATE OF BIRTH____________________________

WHO REFERRED YOU TO OUR CLINIC? ____________________________________

(PLEASE INCLUDE DOCTOR'S FIRST AND LAST NAME IF REFERRED BY PHYSICIAN)

PRIMARY EMERGENCY CONTACT: ______________________________________

PHONE NUMBER: ______________________________________

SECONDARY EMERGENCY CONTACT: ____________________________________

PHONE NUMBER: ______________________________________

I understand that my insurance company/Medicare requires having my signature on file. I request payment of insurance/Medicare benefits be made on my behalf to Spine & Pain Centers of Nebraska. I understand I am responsible for payment in full on my account. <u>**PATIENTS ARE RESPONSIBLE FOR ANY PRE-CERTIFICATION NEEDED FOR ALL INSURANCE . PATIENT IS RESPONSIBLE FOR ACCOUNT BALANCES.**</u>

____ ____________________

Patient's Signature Date

6940 Van Dorn Street ● Suite 201 ● Lincoln, NE 68506 ● Phone: (402) 323-8484 ● Fax: (402) 323-8599
Toll Free (866) 672-4768