Carolina Spine & Hand, PA

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www.CarolinaSpineandHand.com

Patient Information

Patient Name ______________________ Social Security ______________
Date of Birth ______________________
Address ______________________
Mailing Address City State Zip
Telephone Home __________ Work __________ Cell __________

Responsible Party ______________________ Social Security ______________
Date of Birth ______________________
Address ______________________
Mailing Address City State Zip

Relationship (circle one) Self Parent Spouse Other
Telephone Home __________ Work __________ Cell __________
Date of Accident or Injury __________ (circle one) Auto Employment Other

Primary Insurance ______________ Subscribers Date of Birth ______________
Secondary Insurance ______________ Subscribers Date of Birth ______________

Emergency Contact
Name______________ Telephone (H) ______________
Relationship______________ Telephone (W) ______________

Please Read Carefully Before Signing:
I hereby authorize Carolina Spine and Hand Center to release information acquired during the course of my examination and treatment to Health Care Financing Administration and its agents, Medigap or any other third party carrier, as necessary, to secure payment of any benefits to include Medicare and Medigap directly to Carolina Spine and Hand, for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

____
Signature (parent or guardian if patient is a minor) Date

Authorization for Use and Disclosure of Information

I give authorization for my medical information to be released to:

____
Name Relationship

____
Name Relationship

The purpose of the use or disclosure is patient care. I understand that I may revoke this authorization at any time. I understand that this authorization will expire in ten years.

____
Signature of Patient Date