Carolina Spine Center

First Name: _____ MI: ____ Last Name: _____ Date: _____

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

DOB: _____ SS: _____-____-_____ Sex: Male ____ Female ____ Marital Status: _____

Primary Phone #: _____ Cell Phone #: _____

Email: _____ Occupation: _____ Employer: _____

In the event of an emergency please contact: _____

Relation to contact: _____ Phone #: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

Pharmacy: _____ Phone#: _____

Payment Method: Insurance [ ] Self Pay [ ] Workers Compensation [ ]

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

HIPPA Notice of Privacy Practices Acknowledgement & Authorization of Release

HIPPA Notice of Privacy Practices is attached to this clip board and can be provided to the Patient upon their request. Please review and feel free to ask any questions regarding the Privacy Practice Notice.

☐ I authorize the release of medical information for the coordination and management of my healthcare.

☐ I authorize the release of medical information to obtain payment for healthcare services.

☐ I authorize the release of medical information to:

Spouse: _____

Child(ren): _____

Other: _____

Signature: _____