

Comprehensive Spine and Pain Center at Bristol Hospital
PATIENT INFORMATION FORM

Date: _____

How did you hear about us? _____

Patient's Name _____ Date of Birth _____ Social Security Number _____

Mailing Address _____ Apt. No. _____

City _____ State _____ Zip _____

Home Phone with Area Code _____ Cell Phone _____ Sex: M F

Patient Employer _____ Work Phone with Area Code _____

Address _____ City, State, Zip _____

Primary Care Physician's Name _____ Phone with Area Code _____

Address _____ City, State, Zip _____

Referring Doctor _____ Phone with Area Code _____

Address _____ City, State, Zip _____

FILL IN IF PATIENT IS A MINOR

Parent or Guardian Name _____ Date of Birth _____ Social Security Number _____

EMERGENCY CONTACT-Not in same household _____ Phone with Area Code _____

INSURANCE

Primary Insurance _____ Policy Holder Name and Date of Birth _____

Secondary Insurance _____ Policy Holder Name and Date of Birth _____

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Check all that apply:

- Car Accident Work Accident Accident
 Other _____

Date of injury or onset of condition: _____

Brief description of how injury happened or problem started:

Do you have an attorney for this injury? Yes No Name: _____
Address: _____

Patient or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Orthopedic Associate's of Middletown, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment of services rendered to me, and conducting healthcare operations.

Signature _____ Date _____