New Patient Registration

Demographics and Insurance pg1

Patient: Name/First ______________________Middle___________________Last__________________________

SSN: __________-________-____________ Date of Birth: ______/_______/_____ Sex: M | F

Patient street address: ____

Patient address additional: ____

City: _________________________________ State: ________________ ZIP: ___________________-__________

Primary Phone Number: (_________) ___________-_____________ Mobile | Home | Work

Secondary Phone Number: (_________) __________-___________ Mobile | Home | Work

Email address: ____

What is your primary language? _________________________________ Interpreter Required? Yes | No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

---

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity? _____Hispanic or Latino _____ Not Hispanic or Latino _____ I prefer to not answer.
2. How do you identify your race? _____ American Indian or Alaska Native _____ Black or African American _____ Native Hawaiian _____ Other Pacific Islander _____ White or Caucasian _____ Asian _____ I prefer to not answer

---

Who is your primary care physician? _______________________________Phone: ___________________________

Who is the referring physician? ___________________________________Phone: ___________________________

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _______________________________________ Occupation: _______________________PH# ________________

How many employees work? ◯ 1-19 ◯ 20-99 ◯100+ ◯ Don't know

Who would you like to list as an emergency contact?

Name: ____

Relationship to you: ________________________________ Phone Number: (_________) _________-_________________

Insurance #1 Medical Insurance Company Name: ____

Member/Subscriber Identification #: ____________________________ Group #: ___________________________

Medical Insurance Company Address: ____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: _________________

Subscriber: Name: First___________________ Last_______________________ SSN: ________-_______-________ Date of Birth: ________/______/_______ Sex: M | F

New Patient Registration

Demographics and Insurance Pg2

Do you have any additional insurance? Yes | No **Please <u>present all insurance cards</u>**

Insurance # 2 Medical Insurance Company Name: ____
Member/Subscriber Identification #: __________________________ Group #: _________________________

Medical Insurance Company Address: ____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other: ________________

Subscriber: Name/ First__________________Middle________________Last___________________

SSN: ________-_______-________ Date of Birth: ________/______/_______ Sex: M | F

Address: ____

Phone Number: (_______) _______-_____________ Mobile | Home | Work

Do you have any additional insurance? Yes | No **<u>Please present all insurance cards</u>**

IF THIS IS A WORK-RELATED INJURY -PLEASE FILL OUT BELOW

Date of Injury: _______________________________ Claim Number: ____

Name of Insurance Carrier: ____ Name of Claims Adjuster: ____________

Name of Employer: ____

Employers Address: ____

City: ____________________________ State: ________ Zip Code: ________________ Telephone: _________________

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits to Louis H. Rappoport/Arizona Spine Consultants, Ltd.

I understand that I am responsible for any fees or amounts not covered by my insurance company. I also understand that if my insurance company denies payment for my claim, I will pay the outstanding amount immediately or make other payment arrangements. If my insurance company fails to pay my claim, I will be responsible for the payment immediately or make other payment arrangements.

Patient Signature: ____Date: _________________________