**CENTRAL NEBRASKA SPINAL SURGERY CENTER, P.C.**
**PATIENT REGISTRATION FORM**

## PATIENT INFORMATION

Patient Name _____ S.S.# _____
First Middle Last
Mailing Address _____ City, State, and Zip _____

Sex: Male Female Birthdate _____ Home Phone _____

Email: _____ Cell Phone _____

Marital Status: Married Single Divorced Widowed Family/Referring Physician _____

Race _____ Ethnicity _____ Language Spoken _____

Patient Employer _____
Employer Phone _____ Occupation _____

Spouse Name _____ Spouse Employer _____
Spouse S.S.# _____ Spouse Birthdate _____ Spouse Cell Phone _____

Person Responsible for Payment _____ Birthdate _____
Relationship to the Patient _____ S.S.# _____ Phone # _____
Address _____ City, State, and Zip _____
Employer _____ Occupation _____

Emergency Contact (other than spouse) _____
Relationship _____ Emergency Contact Phone _____

Pharmacy of Choice _____ Town _____

## INSURANCE INFORMATION

Primary Insurance Company _____
Policy # _____ Group # _____ Group Name _____
Name of Policy Holder _____ Birthdate _____

Secondary Insurance Company _____
Policy # _____ Group # _____ Group Name _____
Name of Policy Holder _____ Birthdate _____

## ACCIDENT RELATED INFORMATION (Please complete reverse side)

## ASSIGNMENT AND RELEASE

I authorize disclosure of portions of the patient record to determine liability for payment and/or to obtain reimbursement, and I thereby assign all medical/surgical benefits to which I am entitled to Central Nebraska Spinal Surgery Center, P.C. A finance charge of 1% per month will accrue on all unpaid private balances 90 days past due. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

Patient signature _____ Date _____

**Patient Name**_____ **Date**_____

## INJURY INFORMATION

Date of Injury _____ Time _____ a.m. / p.m.

Place of Injury _____

Accident Reported? Yes No Name of person you reported accident to _____

Give full description of how accident happened _____

_____

_____

_____

## WORKER COMPENSATION INFORMATION

### EMPLOYER

Employer Name _____

Employer Address _____

_____

Employer Telephone _____ Injury Verified by (For Office Use) _____

Contact Person _____

### WORKER COMPENSATION CARRIER

Worker Compensation Carrier _____

Carrier Address _____

_____

Carrier Telephone _____ Coverage Verified by (For Office Use) _____

Adjuster's Name _____ Claim Number _____

### AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied.

Patient signature _____ Date _____