TWIN CITIES ✚ SPINE CENTER

Patient Registration Form

PLACE LABEL HERE

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Previous Last _____ Social Security # XXX-XX-_____ Birth Date _____ Sex: ☐ Male ☐ Female

Ethnicity:_____ Race_____ Pref. Language _____ Country of Origin _____

Address _____ Apt/Unit #_____ City/State/Zip _____

   Email Address _____

Please indicate your primary (preferred) phone number by checking the box

☐ Home Phone _____   ☐ Day Phone _____   ☐ Cell Phone_____

Emergency Contact/Alternate Contact Name: _____

   Relationship to patient:_____ Telephone_____

DOCTOR/PHARMACY INFORMATION

Primary Care MD _____ Clinic/City _____/_____

Referring MD _____ Clinic/City _____/_____

Name of Pharmacy_____ Telephone_____

   Address _____ City/State/Zip_____

GUARANTOR (If Patient is under 18)

Last Name _____ First Name _____ Middle _____

Previous Last _____ Social Security # XXX-XX-_____ Birth Date _____ Sex: ☐ Male ☐ Female

Address _____ City/State/Zip _____

Day phone _____ Relationship to Patient _____

HEALTH INSURANCE INFORMATION – (All Patients) (Card must be presented at time of service)

Insurance #1 (PRIMARY)_____ Address _____

Policy/Member #_____ Group # _____ Effective Date _____

*Subscriber: Patient/ Spouse/Parent? **Name**_____ ***DOB**_____ Copay _____

HEALTH INSURANCE INFORMATION – (All Patients) (Card must be presented at time of service)

Insurance #2 (SECONDARY)_____ Address _____

Policy/Member #_____ Group # _____ Effective Date _____

*Subscriber: Patient/ Spouse/Parent? **Name**_____ ***DOB**_____ Copay _____

Please complete this section if your injury is due to: *(Everything below is needed to ensure your claim goes through properly)*

(check one): ☐ Workers Comp ☐ Auto Accident ☐ Liability Claim - Written authorization required

 Insurance Company _____

 Address _____

 Phone _____ Injury Date _____ Claim/File # _____

Claim Adjustor _____ Phone _____ Fax _____

Employer at time of w/c injury _____ Phone _____

I have reviewed the above information. I verify it is accurate.

⭐   **Patient Signature** _____ **Date** _____