PATIENT REGISTRATION FORM

Worker's Comp Y__ N__ Auto Accident Y__ N__ Personal Injury Y__ N__

Last Name:____ First Name:__________________________ M.I:___

Mailing Address:____________________________________ City:___________________ State:___ Zip:______

Home Phone: (______)_______--____________________ Work Phone: (_______) ________--__________

SSN:_________________ DOB:_______________________ Driver's License #:________________ Sex: M F

Marital Status: S M W D O Spouse's Name______________________________

Employer:____ Occupation:________________________________

Employer Address:____

Person to notify in case of emergency:____

RACE:

- ❑ R1 American Indian or Alaskan Native
- ❑ R2 Asian
- ❑ R3 Black or African American
- ❑ R4 Native Hawaiian /Other Pacific Islander
- ❑ R5 white
- ❑ R9 Other Race

ETHNICITY:

__ E1 Hispanic or Latino

__ E2 Non-Hispanic or Non Latino

INSURANCE INFORMATION

Primary Insurance: _________________________________ Subscriber:_________________________________

SSN#:____ Relationship:_______________________________

Claims Address:____________________________________ ID#:_______________________________________

City:___________________ State:_____ Zip:__________ Group#:____________________________________

Telephone: (_______) _______--____________________ Extension:__________________________________

Secondary Insurance:_______________________________ Subscriber:_________________________________

SSN#:____ Relationship:_______________________________

Claims Address:____________________________________ ID#:_______________________________________

City:____________________ State:_____Zip:__________ Group#:____________________________________

Telephone: (_______) _______--____________________ Extension:__________________________________

WORKER'S COMPENSATION INFORMATION

Industrial Carrier:__________________________________ Adjustor:__________________________________

Claims Address:_____________________________________ Claim#:_______________ Date of Injury:_______

City:_________________ State:___ Zip:________________ Phone:_______________ Fax:________________

Attorney Information:_______________________________ Phone#_____________________________________

Case#/Other information:____

Assignment of Benefits – Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to SPINAL DIAGNOSTICS AND TREATMENT CENTER and RICHARD DERBY, M.D. APC, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. In addition, I authorize the release of my records for peer review by physicians in order to ensure the highest quality of care is being provided to me.

Responsible Party:____ Date:_____________