Patient Information

231 733-1326 | www.wmspinecenter.com

Patient Name__________ Birth Date_____ Age___ Sex___ SSN#________

Address__________ City________ State____ Zip______

Phone ________ Cell Phone ________ Email __________

Patient's Maiden Name __________ Seen Before In Office By Dr. ________

If Child, Responsible Party __________ Relationship________

Responsible Party's Birthdate ________ SSN # ________ Contact Phone #________

Employer __________ Address __________

City __________ State ____ Zip _____ Phone ________

Spouse __________ Birth Date ________ SSN# ________

Spouse's Employer __________ Address__________

City __________ State ____ Zip _____ Phone ________

Emergency Contact __________ Phone ________ Alternate Phone # ______

Relationship ________ Referring Physician ________ Family Physician ________

Current Problem __________ Date Of Onset ________

Have you been treated for this condition before? ________ By whom?________

List Allergies __________

List Current Medications __________

Preferred Pharmacy __________ Location __________

Primary Insurance Company __________ Policy # ________

Subscriber's Name __________ Employer ________

Secondary Insurance Company __________ Policy # ________

Subsciber's Name __________ Employer ________

I authorize West Michigan Spine Center or Orthopaedic Associates of Muskegon to release medical information regarding my care to other health care entities for coordination of treatment or continuation of benefits.

Signature: __________ Date: ________

I request payment of authorized BCBSM, Medicare or commercial insurance benefits be made either to myself or on my behalf to West Michigan Spine Center or Orthopaedic Associates of Muskegon, for any services furnished me. I understand the provider's charge may exceed the BCBSM, Medicare, or Commercial payment, and if greater than such payment, I will be responsible for that amount.

Signature: __________ Date: ________