

SPINE & NEURO CENTER

RHETT B. MURRAY, M.D. • JOEL D. PICKETT, M.D.
JOHN D. JOHNSON, JR., M.D. • JASON T. BANKS, M.D. • CHENG W. TAO, M.D.

CO-PAY \$ _____

CHART NO.
DATE

PATIENT'S NAME IN FULL (NO NICKNAMES)		MARITAL					DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NO.
		S	M	W	D	SEP				
ADDRESS		CITY & STATE			ZIP CODE		HOME TELEPHONE NO. ()			
OCCUPATION (INDICATE IF STUDENT)	EMPLOYER		HOW LONG EMPLOYED?			BUSINESS PHONE NO. ()				
EMPLOYERS ADDRESS		CITY & STATE			ZIP CODE					
HUSBAND, WIFE, PARENT OR GUARDIAN NAME		DATE OF BIRTH				SSN				
EMPLOYER OF ABOVE NAME		CITY & STATE			ZIP CODE		BUSINESS PHONE NO. ()			
PERSON TO NOTIFY IN CASE OF AN EMERGENCY										
ADDRESS		CITY AND STATE				ZIP CODE				
HOME PHONE ()		BUSINESS PHONE NO. ()								

REFERRING PHYSICIAN:					
ADDRESS		CITY & STATE		ZIP CODE	PHONE ()
FAMILY PHYSICIAN					
ADDRESS		CITY & STATE		ZIP CODE	PHONE ()

Have you or any member of your family been seen by Dr. Murray, Dr. Pickett, Dr. Johnson, Dr. Banks, or Dr. Tao? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Drs. Name: _____		Patient Name: _____		Approximate Date Seen: _____	

INSURANCE

PRIMARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
SECONDARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
AUTOMOBILE ACCIDENT	OTHER ACCIDENT? SPECIFY:

WORKMAN'S COMPENSATION INFORMATION

WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF ACCIDENT
WORKMAN'S COMPENSATION CARRIER	CLAIM NO.	
ADDRESS		ATTENTION TO:
CITY & STATE		ZIP CODE
PHONE NO.	VERIFIED BY:	
EMPLOYER AT TIME OF ACCIDENT		
DATE OF ACCIDENT	NAME OF ATTORNEY	

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named professional association or hospital to release to my insurers full information, including copies of records and operative notes relative to this illness.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the above mentioned for the benefits payable under the terms of my policy for this period of illness. I understand that I am financially responsible for the charges not covered by this authorization.

DATE _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY