New Jersey Spinal Medicine and Surgery, P.A.
Dante A. Implicito, MD
John D. Koerner, MD

PATIENT INFORMATION: Please use legal name

Name: ________________________________ SS#: ____________________

Date of Birth: ______________ Marital Status: ________________ Sex: ________

Address: ____

City/State: __________________________________ Zip: ____________

Home #: ______________________ Work #: ______________________

Cell #: ______________________ Email: ______________________

Pharmacy Name: ______________________ Pharmacy #: ______________________

REFERRED BY:

○ Doctor: ______________________ ○ Urgent Care: ______________________

○ Patient: ______________________ ○ Internet Search: ______________________

○ Hospital: ______________________ ○ Other: ______________________

PERSON RESPONIBLE FOR BILL: ______________________ Relation to Patient: __________

Address (if different): __________________________________

City/State: __________________________________ Zip: ____________

Phone #: __________________ SS#: ________________ Date of Birth: ____________

I hereby authorize NJ Spinal Medicine & Surgery, P.A. to release all financial and medical information to my insurance companies and referring physician.

Signature: __________________________________ Date: ________________

In order to bill your insurance carrier, we must have your signature on file stating that we have the right to release information necessary for the processing of your claim and authorizing payment directly to NJ Spinal Medicine & Surgery, P.A. With this permission, we will not need your signature every time we bill your carrier.

Signature: __________________________________ Date: ________________

HEALTH INSURANCE INFORMATION (Even if Work or Motor Vehicle injury)

Insurance Co. Name: ____________________

ID#: ____________ Group #: ____________ Phone #: ____________

Insurance Address: ____________ City/State: ____________ Zip: ________

Policy Holder: ____________ Relation to Patient: ____________

Policy Holder DOB: ____________ Policy Holder SS#: ____________

Employer: ____________ Employer Phone: ____________

Employer Address: ____________________

City/State: ____________________ Zip: ____________

SECONDARY HEALTH INSURANCE INFORMATION

Insurance Co. Name: ____________________

ID#: ____________ Group #: ____________ Phone #: ____________

Insurance Address: ____________ City/State: ____________ Zip: ________

Policy Holder: ____________ Relation to Patient: ____________

Policy Holder DOB: ____________ Policy Holder SS#: ____________

Employer: ____________ Employer Phone: ____________

Employer Address: ____________________

City/State: ____________________ Zip: ____________

Is your visit related to a Motor Vehicle Accident? Yes ___ No ___ Date of Accident ____________

Motor Vehicle Insurance Co.: ____________ Claim#: ____________

Insurance Address: ____________ City/State: ____________ Zip: ________

Adjuster Name: ____________ Adjuster Phone#: ____________

Nurse Case Manager: ____________ Nurse Case Manager Phone#: ____________

Is your visit related to a Worker's Compensation Accident? Yes ___ No ___ Date of Accident ________

Worker's Comp. Insurance Co.: ____________ Claim#: ____________

Insurance Address: ____________ City/State: ____________ Zip: ________

Nurse Case Manager: ____________ Nurse Case Manager Phone#: ____________