

New Jersey Spinal Medicine and Surgery, P.A.

Dante A. Implicito, 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 RESPONSIBLE 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#: _____