

# BUFFALO SPINE AND SPORTS INSTITUTE, PC REGISTRATION FORM

## PATIENT INFORMATION

Patient's Last Name			First	Middle	Marital Status (circle one) <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Maiden Name		Parent/Guardian Name			Birth Date		Age	Sex
Street Address		City		State	Zip	Home #	Cell #	Work #
May we leave a message on your personal voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who may we disclose medical/billing information and prescription/medical samples to? (circle one) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other: Name: _____				
E-mail address:					May we contact you via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current Employer Name/Address:					Employer Phone #:		Occupation:	
Referred by: <input type="checkbox"/> Advertisement <input type="checkbox"/> Attorney <input type="checkbox"/> Current patient <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Former patient <input type="checkbox"/> Hospital/ER <input type="checkbox"/> Internet <input type="checkbox"/> Insurance <input type="checkbox"/> Phone Book <input type="checkbox"/> Primary doctor <input type="checkbox"/> Other Medical Specialist (name): _____								
Who is your primary medical physician:								

• Is your visit with us today related to:    Workers' Compensation    Motor Vehicle Accident

## PRIVATE INSURANCE INFORMATION

Person Responsible for Bill:		Birth Date	Address ( if different than patient):		
Is this person a patient here? <input type="checkbox"/> yes <input type="checkbox"/> no		Phone:			
Current Employer Name:		Employer Phone #:		Occupation:	
Is this patient covered by insurance: <input type="checkbox"/> yes <input type="checkbox"/> no					
Please indicate primary insurance: <input type="checkbox"/> Aetna <input type="checkbox"/> BC/BS <input type="checkbox"/> CIGNA <input type="checkbox"/> Community Blue <input type="checkbox"/> Independent Health <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Nova <input type="checkbox"/> United Healthcare <input type="checkbox"/> Univera <input type="checkbox"/> RMSCO <input type="checkbox"/> Tricare <input type="checkbox"/> Other: _____					
Subscriber's Name/Address:		Birth Date:	Policy #:	Group #:	
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____					

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address):		Relationship to patient:	Home phone:	Work phone:
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**The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Buffalo Spine and Sports Institute, PC, and/or insurance company to release any information required to process my claim (s).**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date