Advanced Back Pain & Injury Center

Beyond mere relief – back to full activity fast

ENTRANCE APPLICATION

Welcome! We are honored that you chose us to evaluate your condition, you will not be disappointed! In order for us to better serve you and file your insurance forms for please fill out the form below completely. If you need any assistance please feel free to as our front desk staff. Thank you for taking the time to fill this out.

Name: _____ Date: _____
First Middle Last

Address: _____ City/State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell Phone #: _____

E-Mail: _____

Birth Date: _____ Age: _____ Sex: ❑ M ❑ F Height: _____ Weight: _____

Marital Status: ❑S ❑M ❑D ❑W Spouse's Name: _____ # of Children: _____

Social Security # _____ - _____ - _____ Drivers License #: _____

Employer: _____ Occupation: _____ Insurance? ❑Y ❑N

Insurance Information

Name of person on your Health Insurance Card: _____ Their DOB: _____

Group #: _____ Policy #: _____ Insured's S.S. #: _____

Name of their Employer: _____ Employer Phone #: _____

In case of an emergency, whom should we contact? _____ Relationship: _____

Phone #: _____ Cell #: _____

FAMILY PHYSICIAN _____ Phone #: _____

What is your primary complaint? _____

IS THIS WORKMAN'S COMPENSATION? ❑Y ❑N **IS THIS AN AUTO ACCIDENT?** ❑Y ❑N

Patient Informed Consent

I, _____ the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body may need to be examined. I understand and consent to clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exams(s). If I do consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance, I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____ **Date** _____