

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Maiden Name (If applicable): \_\_\_\_\_

Have we seen you under a previous name? Y \_\_\_\_\_ N \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

If yes, please give the name and approximate year: \_\_\_\_\_

Social Security Number (SS#): \_\_\_\_\_ Marital Status: S\_\_\_ M\_\_\_ W\_\_\_ D\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
Area Code

May we contact you at work? Y \_\_\_ N\_\_\_

Employer name and address: \_\_\_\_\_

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**SPOUSE OR GUARDIAN INFORMATION**

Please provide us with information regarding your spouse, or if the patient is a minor child, the guardian or parent information.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address (If different from the patient): \_\_\_\_\_

Home Phone (If different from the patient): (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Employer name/address/phone number: \_\_\_\_\_

May we contact you here? Y \_\_\_ N\_\_\_

**EMERGENCY CONTACT**

Please provide us with information regarding someone to contact in case of an emergency *who does not live with you.*

Name: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

**INSURANCE INFORMATION**

Are you being seen for an injury? (Work or auto-related) Y \_\_\_ N\_\_\_

**IF YOUR INJURY IS WORK-RELATED, PLEASE COMPLETE THE FOLLOWING:**

Name and Address of Workmen's Compensation Carrier: \_\_\_\_\_  
\_\_\_\_\_

Phone Number of W/C Carrier: ( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code

Name of Contact Person @ W/C Ins. Carrier: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

**IF YOUR INJURY IS AUTO-RELATED, PLEASE COMPLETE THE FOLLOWING:**

Name and Address of Auto Insurance Carrier: \_\_\_\_\_  
\_\_\_\_\_

Name of Contact Person @ Auto Ins. Carrier: \_\_\_\_\_

Phone Number of Auto Ins. Carrier: ( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code

Claim Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

**HEALTH INSURANCE:** (Please present your insurance cards to our receptionist.)

Primary Insurance Company: \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

*I hereby authorize the release of any medical information necessary to process my insurance claims to the above listed insurance companies. This may include information related to HIV, alcohol or substance abuse, mental health or other medical conditions.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I hereby authorize payment of any medical benefits to go directly to the provider of service. I understand that I am responsible for any amounts not covered by my insurance plan. Furthermore, I agree to pay interest on any unpaid balance on my account in the amount of seven percent (7%) per year. I also agree to play all actual attorney fees costs, and expenses incurred by Great Lakes Neurosurgical Associates in attempting to collect any unpaid balance on my account.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_