Southern California Center for Neuroscience and Spine

DATE *(FECHA)* _____

ACCT. # _____

☐ NEW
☐ UPDATE

PLEASE PRINT CLEARLY
FAVOR DE IMPRIMIR

ALL SHADED AREAS MUST BE COMPLETED
DEBEN COMPLETARSE TODAS LAS AREAS SOMBREADAS

PATIENT *(PACIENTE)*

Patient Last Name *(APELLIDO)*	First Name *(NOMBRE DE PILA)*	Initial *(INICIAL)*	Previous Name (Maiden) *(APELLIDO DE SOLTERA)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMENTO)*	
SEX *(SEXO)* ☐ M ☐ F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SOCIAL SECURITY NUMBER *(No. DE SEGURO SOCIAL)*	
MARITAL STATUS *(ESTADO CIVIL)* ☐ S ☐ M ☐ W ☐ D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZÓA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	

RESPONSIBLE PARTY (MAIN INS. CARDHOLDER) (*NOMBRE DE LA PERSONA ASEGURADA)*

PATIENT LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMENTO)*	
SEX *(SEXO)* ☐ M ☐ F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SOCIAL SECURITY NUMBER *(No. DE SEGURO SOCIAL)*	
MARITAL STATUS *(ESTADO CIVIL)* ☐ S ☐ M ☐ W ☐ D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZÓA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CÓDIGO POSTAL)*	

EMERGENCY CONTACT

RELATIVE / FRIEND (Not living at same address) *(REFERENCIA PERSONAL (Que no viva en su mismo domicilio))*

LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)* ZIP *(CÓDIGO POSTAL)*		HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*	ADDRESS *(DOMICILIO)*		EMPLOYER TELEPHONE *(TELEFONO DEL EMPLEADOR)*

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

MEDICARE

Name of Beneficiary _____ Claim # _____

I request that payment of authorized benefits be made either to me or on my behalf to _____ for any services furnished me by my physician. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.

A copy of this signature is as valid as the original.

Signature _____

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature _____