Orthopedic Spine Associates LLC
The Northwest's Center for
Comprehensive Neck and Back Care

PATIENT INFORMATION SHEET: DATE________________

Appointment with: Dr. Kitchel

Name____ Date of Birth:________________________
LAST FIRST MI

Mailing address____
STREET CITY STATE ZIP CODE

Home Phone_________________________Work Phone_________________________Message Phone_______________________

Patient's Employer__________________________________Patient's Driver License Number______________________________

Present Occupation__________________________________Social Security Number____________________________________

( ) Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Dependent ( ) Widowed

Spouse (**or emergency contact**)____Relationship_________________________

Date of Birth_________________Social Security Number________________________Home Phone________________________

Referring Doctor____ Family Doctor_____________________________________

Address____ Address____

____ ____

Phone Number____ Phone Number_____________________________________

SKIP THIS SECTION– UNLESS TODAYS' VISIT IS A

Choose one:

( ) WORK RELATED INJURY OR ( ) MOTOR VEHICLE ACCIDENT

Insurance Company____ Claim Number_____________________________________

Insurance Address____Phone________________ Date of injury_________________

Employer at time of injury___________________________________Occupation at time of injury___________________________

Is your Claim open____ What state did your accident occur in?*__________________

Is this a re-injury of a previous Claim?___________________________ If so, give date of original injury________________________

Is your Claim in litigation?_____________________ If so, name of attorney and any other pertinent information:________________

*We are not subject to out of state workers' compensation programs rules and regulations. We will provide you a billing to submit to your out of state workers comp. program if you wish. You, as the patient, are responsible for full payment of your medical expenses with this office.

INSURANCE

PRIMARY INSURANCE COMPANY

Insurance Name____ Policy Holder's Name____

Insurance Address______________________________________Insurance Phone Number_______________________________________

ID Number____ Policy Holder's sex: ( ) Male ( ) Female

Group Name and Number_______________________________ Policy Holder's date of birth ____________________________________

IF YOU HAVE **MEDICARE** , ARE YOU: ( ) RETIRED OR ( ) DISABLED?

SECONDARY INSURANCE COMPANY

Insurance Name____ Policy Holder's Name____

Insurance Address______________________________________Insurance Phone Number_______________________________________

ID Number ____ Policy Holder's sex: ( ) Male ( ) Female

Group Name and Number_______________________________ Policy Holder's date of birth ____________________________________

I hereby authorize NEUROSURGERY SPECIALISTS to furnish information as necessary to the insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. Additionally, I understand that by signing this agreement, I am financially responsible to NEUROSURGERY SPECIALISTS for payment to be made in a timely manner for my charges, whether or not covered or billed to an insurance company.

PATIENTS SIGNATURE____TODAYS DATE___________________