New Patient Information
(Please print clearly)

Date: ________________

Patient Last Name: ______________________ First Name: ______________ MI: ________

Date of Birth: ___________ Age: ____ Gender: F__ M__ Social Security: _____________

Home Phone: __________________ Work: _______________ Cell: __________________

Address: ____

City: ______________________ State: _____________ Zip Code: ____________________

Email Address: ____

Employer: _____________________________ Occupation: _________________________

Employer's Address: ____

Spouse: ______________________ DOB: _____________ SS#: ______________________

If Patient is a Minor:

Responsible Person: ___________________________ Drivers License #: _______________

Address: ___________________________________ Home Phone: __________________

Employer: __________________________________ Work Phone: __________________

Patient Chief Complaints: ____

Is this visit related to work injury? Y__ N__ Date of Injury: ___________________________

Were you in an auto accident? Y__ N__ Date of Injury: ______________________________

Who may we thank for your referral to our office?_____________________________________

Emergency Contact: _____________________________________ Phone: ______________
(# must be different from home number)

Relationship to Patient: ___________________________________

Patient / Responsible Person Signature: ____

Insurance Plan: _________________ Policy Holder: _______________ Policy ID:________

Secondary: ____________________ Policy Holder: _______________ Policy ID: ________

Auto Liability Info: _______________________________________ Date: _____________

******************************Please Sign All Appropriate Spaces*************************

Assignment of Insurance Benefits: I authorize payment to The B.A.C.K. Center for provider benefits otherwise payable to me, but not to exceed the regular charges for this period of treatment. I understand that I am financially responsible to The B.A.C.K. Center for charges/benefits not covered by this assignment. I also understand The B.A.C.K. Center is not responsible for the terms of the Contract(s) which I have with my insurance company(ies) and that in certain circumstances my insurance company(ies) may determine to pay all, some, or none of the charges resulting from my medical care provided by The B.A.C.K. Center.

Date: ________________ Signature of Policy Holder: ______________________________

Authorization for Treatment
I hereby authorize The B.A.C.K. Center or any of is physicians/providers to evaluate and treat me for conditions requiring medical, surgical, and pain management treatment and those who have attended me to furnish my insurance company(ies) or representative with any and all information that may be contacted in my medical records.

Date: _________________ Signature: ____

Health Information Release Section
In order to assist you in receving your health information from The B.A.C.K. Center, please complete the information below:
I authorize the persons listed below to have access to any and all of my health information, including HIV, drug and alcohol abuse and phsyciatric records. The B.A.C.K. Center is permitted to share any medical information with them, including but not limited to test results and information disclosed during office visits.

Authorized Persons (full name/phone): ____
____

You may notify me of normal test results, appointment reminders and other information regarding my health information as follows (please initial the approved methods):

___Message on answering machine ____Message on voicemail at work
___Message on pager ___Message on cell phone
___Other: ____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

____ __________________
Patient Signature Date

____ __________________
Witness Date