ATLANTIC NEUROSURGICAL & SPINE SPECIALISTS, P.A. ***Demo ck ____***

George V. Huffmon, III, MD, FACS J. Alex Thomas, MD ***HIPAA ck ____***

Jeffrey Probst, PA-C Pedrina Salinas, ANP-BC

PLEASE COMPLETE FORM IN FULL

PATIENT: _____
LAST NAME FIRST NAME MIDDLE/MAIDEN SEX

_____
ADDRESS: STREET P.O. BOX CITY STATE ZIP

(_____) _____-_____ _____ _____ - _____ - _____
HOME PHONE NUMBER DATE OF BIRTH AGE SOCIAL SECURITY NUMBER

(_____) _____-_____ (_____) _____-_____
CELL PHONE NUMBER EMPLOYER WORK PHONE NUMBER

_____ _____ _____ _____ - _____ - _____
SPOUSE'S NAME EMPLOYER DATE OF BIRTH SOCIAL SECURITY NUMBER

_____
NEAREST FRIEND OR RELATIVE TO CONTACT IN CASE OF EMERGENCY HOW RELATED? PHONE NUMBER

_____
EMAIL ADDRESS

REFERRING PHYSICIAN: _____
NAME PHONE NUMBER

FAMILY PHYSICIAN: _____
NAME PHONE NUMBER

REASON FOR VISIT: _____ **ONSET DATE/DATE OF INJURY: _____**

IS THIS A 2ND OPINION: _____PREVIOUS DOCTOR TREATING CONDITION: _____

PRIMARY INSURANCE: _____ POLICY HOLDER _____

POLICY ID#: _____ GROUP# _____

SECONDARY INSURANCE: _____ POLICY HOLDER: _____

POLICY ID#:_____ GROUP#:_____

IF PATIENT IS A MINOR, PLEASE PROVIDE PARENT INFORMATION

PARENT(S) NAME(S):_____

HOME PHONE #: _____ WORK PHONE#: _____

- I hereby authorize and direct payment to Atlantic Neurosurgical & Spine Specialists, P.A. for the medical and/or surgical benefits, if any, otherwise payable to patient under terms of patient's insurance. I understand that the final responsibility of any unpaid balances is mine.
- I hereby authorize Atlantic Neurosurgical & Spine Specialists, P.A. to release any information acquired in the course of patient's examination or treatment to anyone involved in said treatment or payment of treatment.
- It is agreed that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Atlantic Neurosurgical & Spine Specialists, P.A., the cost of reasonable attorney's fees will be added to the outstanding balance. Any outstanding balances on my account over 90 days old may be subjected to a 1-½ % per month (18% annual) finance charge.
- I hereby authorize photocopies of this form to be as valid as the original.

XX XX

Patient/Parent (Guardian) Signature Date (rev 1-12)