SPINE AND ORTHOPEDIC CENTER OF NEW JERSEY, LLC

90 SPARTA AVE, SPARTA, NJ 07871 PHONE (973) 726-9500 FAX (973) 726-8218

PATIENT INFORMATION

PATIENT'S NAME: _____ DOB: _____ SEX: M /F SS#: _____

ADDRESS: _____ TOWN: _____ STATE: ___ ZIP CODE: _____
*** (DO NOT USE P.O. BOX)**

HOME PHONE #: _____ CELL #: _____ WORK #: _____

SPOUSE/PARENT(S) NAME: _____ DOB: _____ PHONE NO.: _____

EMERGENCY CONTACT: NAME _____ **RELATIONSHIP:** _____

TELEPHONE: HOME _____ WORK _____ CELL _____

***NEED (IF YOU HAVE ONE) YOUR E-MAIL ADDRESS**: _____

INSURED'S EMPLOYER: _____ OCCUPATION: _____
EMPLOYER'S ADDRESS: _____ TELEPHONE#: _____

***PRIMARY CARE PHYSICIAN:** _____ **TELEPHONE#:** _____
ADDRESS: _____ _____ ____ _____
TOWN STATE ZIP CODE

****

MUST BE FILLED IN IF AN MVA CASE

YOUR MVA INSURANCE INFORMATION
CLAIM #: _____
INSURANCE NAME: _____
ADJ. NAME: _____
ADJ. PH#: _____

OTHER PARTY'S MVA INSURANCE INFORMATION
CLAIM #: _____
INSURANCE NAME: _____
ADJ. NAME: _____
ADJ. PH#: _____

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PRIVATE INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____
POLICY HOLDERS' NAME: _____ ID#: _____
INSURED'S SS # _____-_____-_____ INSURED'S DOB: _____

SECONDARY INSURANCE COMPANY NAME: _____
POLICY HOLDERS' NAME: _____ ID#: _____
INSURED'S SS # _____-_____-_____ INSURED'S DOB: _____

REFERRED BY: ☐ FRIEND: _____ ☐ DOCTOR: _____

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ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE OR INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I ASSIGN TO DR. BASCH ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT, FOR SERVICES RENDERED TO ME BY DR. BASCH. I AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO MY CLAIMS BY DR. BASCH TO BE RELEASED TO DR. BASCH. I AUTHORIZE DR. BASCH TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO DR. BASCH.

PATIENT SIGNATURE: X _____ DATE: _____

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