Mr. /Mrs. / Ms. /Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST NAME FIRST NAME MIDDLE INITIAL

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STREET CITY STATE ZIP CODE

Telephone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_ Self Spouse Parent

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*ALL THREE QUESTIONS BELOW MUST BE ANSWERED\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Condition or open case related to Motor vehicle accident: YES NO

Workman’s Compensation: YES NO

Legal case or other personal injury Case: YES NO

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (if other than above): Friend/ Relative Physical Therapy Internet Other

**Office Policy please read and initial the following:**

* I understand that I may be charged a $50 failed appointment fee for an office visit/ follow up and $150 failed appointment fee for injection visits when 24 hours’ notice is not provided. **\*\*\*Initial**\_\_\_\_\_\_\_\_\_
* I understand that I am responsible to obtain all referrals from my primary care provider if required by my insurance/policy. I understand I will be held financially responsible for charges if referral is not obtained. **\*\*\*Initial\_\_\_\_\_\_\_\_\_\_**
* I hereby authorize payment directly to Princeton Spine and Joint Center of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid/covered by insurance. I authorize the above provider to release all information required to secure the payment of insurance benefits. I authorize the use of this signature for all insurance submissions.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_