

Minimally Invasive Spine Specialists, S.C.

Patrick J. Sweeney, M.D. Augusto R. Chavez, M.D. Raymond Hines, III, PA-C

Name: Last _____ First _____ MI _____

Address: _____ City/State/Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Birthdate: ____/____/____ Sex: M F

Status: Single Married Divorced Widow(er)

Social Security #: _____ - _____ - _____ E-Mail Address: _____

Person responsible for bill: _____ Social Security #: _____ - _____ - _____

Address: _____

Phone: (____) _____ - _____ Birthdate: ____/____/____

Employment

Employer: _____

Address: _____

Phone: (____) _____ - _____

Insurance

Primary Insurance Name: _____ Phone: (____) _____ - _____

Address: _____ Claim #: _____ ID #: _____

Secondary Insurance Name: _____ Phone: (____) _____ - _____

Address: _____ Claim #: _____ ID #: _____

Attorney's Name: _____

Address(s): _____

Referral

Referred By: _____ Primary Care Physician: _____

Emergency Contact

Emergency Contact Name: _____ Relation: _____

Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Consent is hereby given for treatment, examination or diagnostic tests as prescribed by my physician to be performed by Minimally Invasive Spine Specialists, its agents, and employees.

I authorize Minimally Invasive Spine Specialists, SC to release information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I authorize and direct my insurance to issue payment for services directly to Minimally Invasive Spine Specialists, SC. Regardless of my insurance benefits, if any, and in the event of nonpayment, I understand that I am responsible for fees and services rendered.

***Signature: _____ Date: _____