

## PATIENT APPLICATION FORM

Name: _____	Age: _____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Address: _____	Birthday: _____	
City: _____	State: _____	Zip: _____
Email: _____		
Phone: Home _____	Cell _____	Work _____
Marital Status: _____	# of Children: _____	Ages: _____
Employer: _____	Type of work: _____	

How were you referred to our office? \_\_\_\_\_

## INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing this service strictly as a convenience for me. Advanced Spine will provide any necessary reports or required information to aid in insurance reimbursement for services. I understand that insurance carriers may deny my claims and that I am ultimately help responsible for any unpaid balance. Any monies received will be credited to my account.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian/Spouse Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured's SS #: \_\_\_\_\_

Relationship to the Insured: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_

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

Who should receive charges on your account?

- Patient       Spouse       Parent/Guardian       Worker's Comp       Auto Insurance  
 Medicare       Health Insurance

## EMERGENCY CONTACT INFORMATION

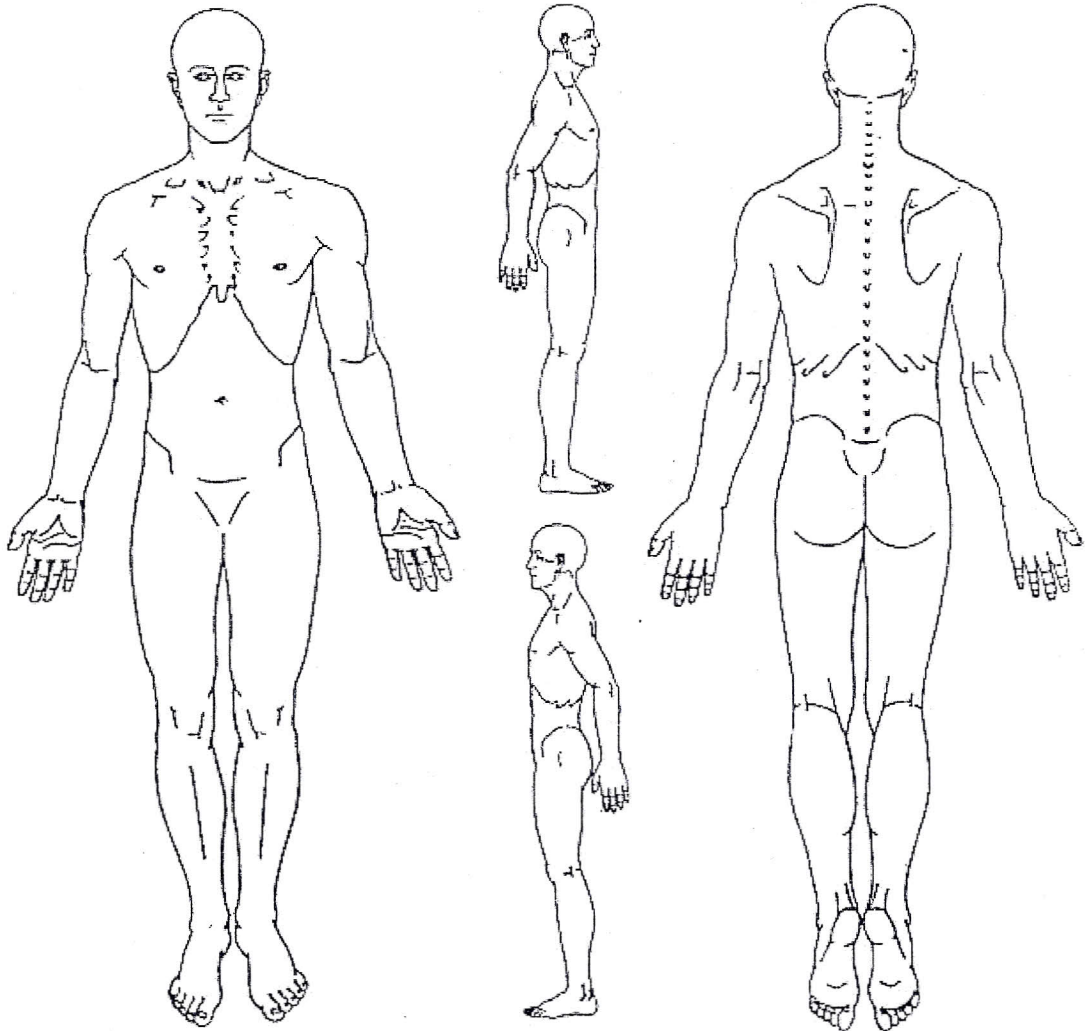
Name: _____	Relationship: _____
Phone Number: _____	cell/home/work

## THE REVISED OSWESTRY PAIN QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

How long have you had back pain \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

On the diagram below, please indicate where you are experiencing pain, right now. please complete both sides of this form.



A = ACHE  
O = OTHER

B = BURNING  
S = STABBING

N = NUMBNESS  
P = PINS & NEEDLES

# FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

**Patient:** \_\_\_\_\_

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Problems										
Stomach Problems										
Other:										

If any of the above family members are deceased, please list their age at death and cause of death: