



spinalrehab
OF NORTH COUNTY

New Patient Questionnaire

Patient Information

PLEASE PRINT

Name: _____ Date: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Circle One: Male Female Circle One: Single Married Divorced Widowed Separated

Birth date: _____ Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Whom may we thank for referring you to us? _____

Did you see our Mail Flyer? _____ Website? _____ Other? _____

Name of local primary physician: _____

Claim Information

Is your condition due to an: Auto Accident ___ Personal Injury ___ Work Injury ___ Other ___

Type of Claim: Cash ___ Group Health Insurance ___ Personal Injury ___ Worker's Comp ___ Medicare ___

Auto Accident Information:

Car Insurance? _____ Claim #: _____

Claim Adjuster's Name? _____ Contact #: _____ ext: _____

Insurance Information-If insured, Please provide a copy of insurance card. We will do a complimentary benefits check for you.

Relationship To Insured? Self ___ Spouse ___ Other ___ Child ___ Spouse Name: _____

Insured's Employer _____ Same as above ___

Insured's SSN _____ Same as above ___

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office. I also agree to all the office policies, of which I can request a copy to review.

Patient Signature _____ Date: _____