

Stanley Jones, MD



Kenneth Lee, MD

SPINE CARE

7500 Beechnut, # 150 Houston, TX 77074

REFERRAL INFORMATION

REFERRAL INFORMATION: please let us know whom we can thank for your referral to Spine Care.

Physician Name: _____ **Address** _____ **Phone ()** _____

Friend/Patient: _____ **Insurance:** _____ **Other:** _____

PATIENT INFORMATION

Name: _____

Employer: _____

Address: _____

Work Phone: _____

City, St, Zip: _____

Employer Address: _____

Date of Birth: _____ Gender: M F

City, St., Zip: _____

Marital Status: M S D W

Nearest Relative / Emergency Contact

Home Number: _____

Name/Relation: _____

Cell Number: _____

Phone: _____

Email Address: _____

Please let us know the best way to get in touch with

Drivers License Number: _____

you during the day: home # email work # cell #

SSN #: _____

Is today's visit due to a work-related injury: Yes No ***Auto Accident:*** Yes No ***Fall:*** Yes No

Primary Insurance Name: _____

Secondary Insurance Name: _____

Address: _____

Address: _____

City, St, Zip: _____

City, St, Zip: _____

Insured: _____ DOB: _____

Insured: _____ DOB: _____

Member #: _____ Group: _____

Member #: _____ Group: _____

Insured's Employer: _____

Insured's Employer: _____

Employer Phone#: _____

Employer Phone#: _____

Employer Address: _____

Employer Address: _____

City, St, Zip: _____

City, St, Zip: _____

ASSIGNMENT OF BENEFITS & RELEASE AUTHORIZATION (EXCLUDING WORKER'S COMPENSATION)

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING PRIVATE INSURANCE, TO SPINE CARE, P.A. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED VALID AS ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION DEEMED NECESSARY FOR MY TREATMENT TO INSURANCE COMPANY AND TO ANY OTHER MEDICAL PROVIDER TO WHOM I AM REFERRED. IN ADDITION, I UNDERSTAND THAT I AM LIABLE FOR A **\$25.00** CHARGE IN THE EVENT OF A MISSED/BROKEN APPOINTMENT WITHIN LESS THAN A 24 HOUR CANCELLATION NOTICE.

SIGNATURE: _____ **DATE:** _____