

Maine Medical

PARTNERS

Neurosurgery & Spine

neurosurgeryandspineassociates.com

- 49 Spring Street, Scarborough, ME 04074
- 46D First Park Drive, Oakland, ME 04963
- 121 Medical Center Drive, Suite 3500, Brunswick, ME 04011

Patient Information

Patient's Name				Age:
First Name	MI	Last		Date of Birth: ___/___/___
<input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D			SS#:
If patient is a child, enter parent's name:	First Name	MI	Last	
Address: Street	City		State	Zip Code
P.O. Box	City		State	Zip Code
Home Phone:	Employed By:			
Work Phone:	Employer Address:			
	Occupation:			
Name and Address for Billing Purposes:			Relationship:	
Address:			Telephone:	
Person to contact for Emergency:			Relationship:	
Telephone:				
Family Doctor:			Telephone:	
Address:				
Referring Doctor:			Telephone:	
Address:				
Have you obtained the necessary insurance referral? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please obtain your authorization number <input type="text"/>				
If no, please contact your Primary Care Physician.				
Are there any religious or other restrictions on the medical care you receive?				
Have you been treated for this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, by whom and where?:				
Was an X-ray or MRI taken?: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, when?:				
Where?:				

Please complete reverse side

Insurance Information
 (Please bring your insurance card with you at the time of your appointment)

Primary Insurance Company: Address:	Policy Owner's Name: Date of Birth:	Certificate #: Group #:
Secondary Insurance Company: Address:	Policy Owner's Name: Date of Birth:	Certificate #: Group #:

<input type="checkbox"/> Medicare	Identification #:
<input type="checkbox"/> Medicaid	Identification #:

For Auto Accident cases only: Auto Insurance Company: Address: Telephone #:	Policy Owner's Name: Policy #: Date of Accident:
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Are you represented by a lawyer? Yes No
 If yes, lawyer's name/address:
 Telephone:

If this is a Workers Compensation Injury please fill out the information below.

Date of Injury: _____ Date injury reported to employer: _____

Did your Workers' Compensation Insurer send you here today? Yes
 No

WC Insurance Carrier: Address: Adjuster Name: Telephone:	Claim #:
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Are you currently working?: Yes
 No If no, date you last worked: _____

Authorization

I understand that even though I may have insurance coverage, I am financially responsible for payment of services.

- I hereby authorize release of medical information for processing insurance claims.
- I hereby authorize payment directly to Neurosurgery Associates P.A. or Maine Spine & Rehabilitation.
- I hereby authorize the release of medical information to physicians and others responsible for my care.

Date: _____ Signature: X _____

Some medical insurance plans require a second surgical opinion and Prior Authorization of any surgery. It is your responsibility to follow your insurance company's guidelines for proper reimbursement. If you have questions, our office staff can assist you.