



Date: _____

Doctor(circle): Dixon White Lakatos

We are required to have the information below in order to comply with the rules and regulations of your insurance carrier. **YOU MUST FILL OUT ALL SECTIONS OF THIS FORM. If we have incomplete or missing information, you will be responsible for charges relating to your visits with our office.** If you have any questions please ask. Thank you.

IF YOUR APPOINTMENT IS IN REFERENCE TO A CAR or other ACCIDENT (except workers compensation), THE PHYSICIAN MAY BE UNABLE TO SEE YOU UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION:

Patient Name _____ Home Phone _____
Street, Apt. _____ Work Phone _____ Ext: _____
City, State _____ Zip _____ Other Number _____
Birth date _____ Age _____ Best Time to Call: _____
Patient Social Security _____ - _____ - _____ (sorry, but we must have SS # to bill insurance carrier)
Place of Employment _____ or not currently employed

Marital Status: M S D W Sex: M F Email _____ @ _____

Name and phone number of person to contact in case of an emergency:

Family Doctor: _____ Phone Number: _____
Family/Friend: _____ Phone Number: _____

PRIVATE INSURANCE INFORMATION I do not have insurance

Primary Insurance _____	Second Insurance _____
Policy Holders Name _____	Policy Holders Name _____
Policy Number _____	Policy Number _____
Group Number _____	Group Number _____
Effective Date _____	Effective Date _____
Policy Holder Social Security # _____	Policy Holder Social Security # _____
Policy Holder Employer Name _____	Policy Holder Employer Name _____
Policy Holder Date Of Birth _____	Policy Holder Date Of Birth _____

IF THIS IS A WORK INJURY, PLEASE PROVIDE THE NECESSARY DOCUMENTATION

BUREAU OF WORKERS COMPENSATION INFORMATION

Claim Number _____ Date of Injury _____ Attorney Name _____
Employers Name AT TIME OF INJURY _____
Provider/Doctor of Record as listed with BWC _____

Please be aware that we are not able to accept all referrals we receive. In order to stay within the guidelines of our office, we must decline some cases. All necessary parties will be informed of the reason for declining the referral. Thank you for your understanding.

Insurance, Medicare, and Workman's Comp Authorization – PLEASE READ & SIGN BELOW

(Gives us your permission to send bill to the Insurance(s) you have indicated above)

I hereby authorize Columbus NeuroSurgical Spine Group to submit a claim to my insurance or workers comp. carrier for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to the physician rendering the covered services. I understand that for Medicare, state or other public assistance or for certain contracted HMO's, PPO's, etc. I will be responsible for those charges deemed not covered by said insurance carrier so long as such insurance has not deemed such services to be medically inappropriate or unnecessary. I also understand that if my insurance company is not a contracted carrier, I am responsible for; the fee charged by my physician regardless of what my insurance pays. I authorize TurboOffice.com to furnish complete information to my insurance or workers comp. carrier and its intermediaries regarding the services rendered. I permit a copy of this authorization to be used in place of the original. I understand that this information may be transmitted electronically.

Signature _____ Date _____

Witness _____ Date _____

Drug Allergies?: _____