SYNERGY
PHYSICIAN GROUP, P.A.
The Leader in Spinal Medicine and Minimally Invasive Spinal Surgery

PATIENT INFORMATION ACCOUNT #_____

NAME: LAST: _____ FIRST: _____MIDDLE: _____

ADDRESS: _____CITY: _____

STATE: _____ ZIP CODE: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____WORK PHONE: _____

CONTACT PREF: ☐ HOME ☐ CELL ☐ WORK SEX: ☐ MALE ☐ FEMALE RACE: _____ ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED (SPOUSE'S NAME) _____

☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

ARE YOU CURRENTLY WORKING WITH AN ATTORNEY? ☐ YES ☐ NO

IF YES, DOES THE CONDITION WE ARE SEEING YOU FOR INVOLVE YOUR ATTORNEY OR JOB RELATED INJURY? ☐ YES ☐ NO

IS THE INJURY OR PROBLEM RELATED TO A WORKER'S COMPENSATION CLAIM? ☐ YES ☐ NO
IF WORKER'S COMPENSATION IS THERE AN ASSIGNED ADJUSTER?

NAME: _____ ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT

NAME: LAST _____ FIRST: _____RELATIONSHIP: _____

PHONE: _____ ADDRESS: _____

PHARMACY CONSENT

********* MEDICATION HISTORY CONSENT TO VIEW INFORMATION *********
I hereby grant permission to Synergy Physician Group, PA, to view my prescription history from external sources.

PATIENT SIGNATURE: _____ DATE: _____

INSURANCE INFORMATION
PRIMARY INSURANCE CARRIER: _____ID: _____

GROUP #: _____ EMPLOYER FOR POLICY HOLDER: _____

POLICY HOLDER NAME: _____ DOB: _____ SEX: _____ SSN:_____

SECONDARY INSURANCE CARRIER: _____ID: _____

GROUP #: _____ EMPLOYER FOR POLICY HOLDER: _____

POLICY HOLDER NAME: _____ DOB: _____ SEX: _____ SSN: _____

AUTHORIZATION TO RELEASE INFORMATON AND ASSIGNMENT OF BENEFITS
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Synergy Physician Group, PA to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Synergy Physician Group, PA.

I attest that the information above is true and current to the extent of my knowledge. I understand that I am responsible for any amounts not covered by my insurance carrier and agree to pay my balance in a timely manner.

A 15% fee and/or usual and customary attorney fees will be charged for any balances subject to collection procedures.

PATIENT SIGNATURE: _____ DATE: _____