SALTERS CREEK
MEDICAL GROUP
"Specializing in Non-Operative Care of the Spine"

REGISTRATION

DATE: _____

Thank you for selecting our healthcare team! We strive to provide you with the best possible healthcare. To help us meet all your needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION

Name: _____ Soc. Sec. # _____
Last Name First Name Initial

Address: _____

City: _____ State: _____ Zip: _____

Sex M F Age: _____ Birthdate _____ Home Phone: _____ Pager: _____

Other Phone: _____ Your Employer: _____ Work Phone: _____

Business address: _____

In case of emergency contact: _____ Are You? Single Married Separated Divorced

Spouse's Name: _____ Spouse's address & phone#: _____
(If different from your own)

Are You a Student? Full time Part time School: _____ _____

PRIMARY INSURANCE

Person Responsible for Account: _____ Relation to Patient: _____
Last Name First Name Initial

Address: (if different than Patient's) _____

Birthdate: _____ Soc. Sec. # _____ Phone # _____

Person Responsible Employed by: _____ Occupation: _____

Business Address: _____ Phone # _____

INSURANCE COMPANY: _____

Please allow the receptionist to make a copy of your insurance card.

Insurance # _____ Group # _____ _____

ATTORNEY & AUTO OR WORK RELATED ACCIDENT INFORMATION

Date of Accident:_____ Time: _____ Type of Accident: Auto? Work Related? Slip and Fall?

If any other, Please explain: _____

Location of Accident:_____ _____Town:_____

Did you go to the Emergency room? Yes No If Yes, What Hospital? _____

Were X-Rays taken? Yes No NAME OF YOUR ATTORNEY: _____

Name of Attorney's Firm: _____ Phone: _____

Attorney's Address: _____

AUTHORIZATION, ASSIGNMENT, AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the case of default on payment on my account, I agree to pay collection costs and reasonable attorney fees of 33.33% incurred in attempting to collect on this amount or any future outstanding account balances.

X _____ _____
Signature of patient or parent if minor Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

_____Cash

_____Personal Check

_____Credit Card _____Visa _____MC Card Number: _____

_____I would like to finance my visits with American General Finance.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.