NYC DISC
Spinal Decompression Specialists

PATIENT INFORMATION FORM

Appointment with Dr. ______________________ on ____/____/____

Translator Necessary ☐ Yes ☐ No

Last Name	First	Middle initial / Maiden Name	Date of Birth	Sex: Male ☐ Female ☐	Home Phone # ( )
Mailing Address	Apt. / Lot	City	State/Zip	How Long At Present Address?	Social Security #
Alternate Mailing Address	Apt. / Lot	City	State/Zip	How Many Months at this Address?	

Material Status: ☐ Divorced ☐ Married ☐ Widowed ☐ Single ☐ Separated	Mother's Name (If Minor Patient)	Father's Name (If Minor Patient)	Drivers License #
Occupation of Patient	Employer/Company Name	Employer Address	Employers Phone # ( )

Spouse"s Name	Spouses Social Security#	Spouses Employer	Spouses Employer Address	Spouses Employers Phone# ( )

Allergies:	Do You Drink? ☐Yes ☐No	Do You Smoke ☐ Yes ☐ No

INSURANCE INFORMATION

INSURANCE INFORMATION *Please write information about the patient's insurance here*

Primary Insurance Company Name			Secondary Insurance Company Name		
Insurance Company Address			Insurance Company Address		
City	State	Zip	City	State	Zip
Insurance ID Number	Group Plan Number		Insurance ID Number	Group Plan Number	

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

Is the secondary policyholder the: ☐ *Patient* ☐ *Primary Policyholder* ☐ *Other*

(Complete the information below if you checked "Other")

Primary Policyholder's Name (Last, First, Middle Initial			Date of Birth / /	Secondary Policyholder's Name (Last, First, Middle Initial)			Date of Birth / /
Primary Policyholder's Address			Sex ☐ Male ☐ Female	Secondary Policyholder's Address			Sex ☐ Male ☐ Female
City	State	Zip	Telephone ( )	City	State	Zip	Telephone ( )
Employer's Name or School Name			Telephone	Employers Name or Schools Name			Telephone ( )
Employer"s Address				Employer"s Address			
City		State	Zip	City		State	Zip
Social Security Number			Relationship to Patient ☐Spouse ☐Parent ☐Other______	Social Security Number			Relationship to Patient ☐ Spouse ☐Parent ☐ Other______
Employer Plan Coverage ☐Yes ☐ No	If Champus; ☐Active ☐ Retired ☐Disabled	Branch of Service ______		Employer Plan Coverage ☐ Yes ☐ No	If Champus; ☐ Active ☐Retired ☐Disabled	Branch of Service______	

GUARANTOR INFORMATION

Head of Household/Custodial Parent of Minor Child		Relationship to Patent		Guarantor's Social Security #
Mailing Address	Apt/Lot	City	State/Zip	Gua rantor's Phone # ( )
Guarantor Employer	Employer's Address	City	State/Zip`	Employer's Phone # ( )
Guarantor's Occupation	Drivers License #	Person Completing Form/Relationship to Patient		

(Please complete sheet 2)