300 StoneCrest Blvd Ste. 230
Smyrna, TN 37167

PH: 615-730-8626
FAX: 615-840-6169

www.sos-tn.com

PATIENT INFORMATION

Preferred Pharmacy ______ Location ______

First Name ______ Last Name ______

Middle Name ______ Date of Birth ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

Social Security No. ______ Primary Language ______

Gender ☐ Male ☐ Female

Ethnicity ☐ Decline ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race ☐ Decline ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Marital Status ☐ Married ☐ Unmarried ☐ Divorce ☐ Single

Home Address

Address ______

City ______ ZIP Code ______

State ______

E-mail ______

Home No. ______

Cell No. ______

Employer Address

Address ______

City ______ ZIP Code ______

State ______

Occupation ______

Work No. ______

Preferred Method of Contact ☐ Mail ☐ Phone ☐ Cell ☐ Text

REASON FOR VISIT

What is the problem you are being seen for? ______

Is this due to an Injury? ☐ Yes ☐ No

If Yes, what was the date of the injury ______

If Yes, check one ☐ Auto Accident ☐ On the Job

Other, Specify ______

Was the Patient seen in the ER? ☐ Yes ☐ No

No, If yes, Hospital and Date ______

Note: If you have had radiologic images taken for this problem at another facility, your insurance carrier may not pay for repeat images.

EMERGENCY CONTACT

Name ______ Relationship ______

Contact No. ______ Alternate No. ______

300 StoneCrest Blvd Ste. 230
Smyrna, TN 37167

PH: 615-730-8626
FAX: 615-840-6169

www.sos-tn.com

Patient Name ____________ Date of Birth ____________

REFERRAL INFORMATION

How did you learn about our practice? ☐ Doctor ☐ Family/Friend ☐ Website ☐ Advertisement ☐ Other ____________

Referring Doctor's Name ____________ Phone No. ____________

Primary Care Physician ____________ Phone No. ____________

RESPONSIBLE PARTY INFORMATION

☐ Someone other than the patient is the responsible party and/or is the insured, such as a spouse or legal guardian accompanying a minor child

First Name ____________ Last Name ____________ Middle Initial ____________

Address ____________ Home No. ____________

City ____________ Work No. ____________

State ____________ ZIP Code ____________ Social Security No. ____________

Date of Birth ____________ Employer ____________

INSURANCE INFORMATION

Primary ____________ Group No. ____________ Policy No. ____________

Name of Insured ____________ Date of Birth ____________ Relationship to Patient ____________

Secondary ____________ Group No. ____________ Policy No. ____________

Name of Insured ____________ Date of Birth ____________ Relationship to Patient ____________

In order to maintain accurate and up to date medical records, we request permission to query outside resources for a list of current medications. Your signature below indicates that you agree and give us your permission.

Signature of Patient or Responsible Party ____________ Today's Date ____________

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please know that you are responsible for all deductible, co-pay, and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information and appeals necessary to process my claim(S). I authorize payment(s) of medical and surgical benefits to Spine and Orthopedic Solutions.

Signature of Patient or Responsible Party ____________ Today's Date ____________