EAST BAY BRAIN & SPINE
MEDICAL GROUP

PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Patient Middle Name:
Is this your legal name? YES NO	If not, what is your legal name?	Former Name:
Circle One: Mr. Mrs. Ms. Miss	Sex: Male Female	Social Security Number:
Patient DOB:	Marital Status: Single Married Divorced Separated Widowed	
Patient Street Address:		
City:	State:	Zip:
Patient Home Phone:	Patient Cell Phone:	
Patient Email Address:		
Occupation	Employer:	Work Phone:
Language Preference:	Race:	Ethnicity
Primary Care Provider:	Referring Provider:	

INSURANCE INFORMATION

PLEASE BRING A COPY OF YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT.

PRIMARY Insurance Carrier:		circle one: Health Insurance Workers' Comp Lien
ID#:	Group ID:	Group Name:
Co-Pay:	Issued:	Phone:
Claims Address:		
Subscriber's Name:	Subscriber's DOB:	Relationship (circle one): Self Spouse Child Other: ___________________

SECONDARY Insurance Carrier (if applicable):		circle one: Health Insurance Workers' Comp Lien
ID#:	Group ID:	Group Name:
Claims Address:		
Subscriber's Name:	Subscriber's DOB:	Relationship (circle one): Self Spouse Child Other: ____________________

IN CASE OF EMERGENCY

Name of local friend/relative:	Relation to patient:	Contact Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be pain directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Bay Brain & Spine Medical Group or insurance company to release any information required to process my claim.

Notice to consumers:
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov

______________________________	______________________	__________________________
Signature of Patient/Legal Representative/ Spouse/Financially Responsible Party	*Date/Time*	*Relationship to Patient*