

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_

Are you under 18 years old? Y / N If yes, please print name of Parent or Legal Guardian: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ Phone#: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Responsible Party/Guarantor** (Person responsible for paying on account, if different from Patient)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Injury Information**

Worker's Comp: Yes No Date of Injury: \_\_\_\_\_  
Motor Vehicle Accident: Yes No Date of Injury: \_\_\_\_\_  
Other Accident/Injury: Yes No Type of Injury: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**Previous Imaging or Testing** (Please be sure to bring any copies of testing and reports as well as imaging on a CD to your visit)

Any Previous Imaging/Testing: Xrays MRI CT EMG Other: \_\_\_\_\_  
Facility where and body part testing done: Xrays: \_\_\_\_\_ MRI: \_\_\_\_\_  
CT: \_\_\_\_\_ EMG: \_\_\_\_\_ Other: \_\_\_\_\_

**Insurance Information**

**Primary Insurance**

Insurance Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Deductible: \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Co-Ins: \_\_\_\_\_

**Secondary Insurance**  Yes  No

Insurance Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Deductible: \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Co-Ins: \_\_\_\_\_

**Policy Holder Information**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Cell # \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Holder Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Card ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Policy Holder Information**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Cell # \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Holder Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Card ID#: \_\_\_\_\_  
Group #: \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Worker's Comp/Carrier Information**

Contact: \_\_\_\_\_ Claim#: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ State of where injury occurred: \_\_\_\_\_  
Notes: \_\_\_\_\_

**Auto Insurance Information** (Please remember to bring a Copy of the Declarations page from your Auto policy to your visit)

Carrier: \_\_\_\_\_ Contact: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Injury Description: \_\_\_\_\_  
State where MVA occurred: \_\_\_\_\_  
Does policy include "Med Pay"?  Yes  No Dollar Limit: \$ \_\_\_\_\_  
Have "Med Pay" benefits exhausted?  Yes  No  
Notes: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Name of Patient: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

I hereby acknowledge that I received a copy of CTNB’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Received: \_\_\_\_\_  Refused/Reason: \_\_\_\_\_

“Good Faith” Efforts to Obtain: \_\_\_\_\_

**FINANCIAL AGREEMENT**

I understand that any bills I incur at CTNB are ultimately my responsibility. Although Connecticut Neck and Back Specialists, LLC staff rigorously attempt to verify all insurance plans and coverage, it is my responsibility to know whether my plan is in network or out of network, or whether certain services are covered by my plan. I am responsible for any co-pays and/or deductibles as described in the terms of my insurance. If my insurance company or worker’s compensation carrier denies my claim, if my motor vehicle accident insurance becomes exhausted, or if my medical insurance term runs out during my treatment here, I will take responsibility for all payments of any outstanding bills.

If my insurance is part of an HMO or managed care organization, I understand that I will be responsible for making payments for any treatment I receive from a physician/provider at this office that may not be affiliated with my plan. I understand that my insurance plan may have a referral or authorization process that must be followed in order for services to be paid. I understand that I am responsible for payment of any care I receive beyond that which is authorized and for any care I receive that is not covered under my plan.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_