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: _____

_____

39 Hospital Avenue
Danbury, CT 06810
Tel: 203 744 9700
Fax: 203 744 9701

www.ctneckandback.com

David L. Kramer, M.D.
David A. Bomback, M.D.
Raj J. Gala, M.D.
Stephen A. Weyel, PA-C

Insurance Information

Primary Insurance
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#:_____

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#:_____

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: _____

PATIENT SATISFACTION SURVEYS

We may occasionally text or email you to follow-up on your experience with our office. If you would prefer we not contact you in this way, please check here: ☐ Opt-Out of any practice marketing

My signature below authorizes communication for the purposes noted above.

SIGNATURE: _____ DATE: _____

FINANCIAL AGREEMENT

CTNB is committed to providing you with the best possible care and are pleased to discuss our professional feels with you at any time. Billing of insurance is a courtesy we provide to our patients and is not required by law. Please sign below to indicate your agreement with our policies: I understand that any bills I incur at CTNB are ultimately my responsibility. I am responsible for any co-pays, deductibles and/or any monies identified by my insurance carrier as "patient responsibility," 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. I agree to make co-payments and estimated deductible payments at the time service are rendered. 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: _____