SCORE

Today's Date_____

Last Name_____Middle_____First_____Sex: Male____Female_____

Street Address_____City_____State_____Zip_____

Home phone_____Work phone_____Cell _____

Email_____What is the best way to reach you during the day?_____

Date of Birth_____Age_____Social Security #_____Marital status_____

Employer's name_____

Employer's address_____

Next of

Kin_____Relationship_____Phone_____

Spouse's Name _____Date of Birth_____Age_____SS#_____

Spouse's Employer name _____Work Phone_____

Patient Emergency contact information

1. Name_____Relationship_____Phone_____
2. Name_____Relationship_____Phone_____

HOW DID YOU HEAR ABOUT US? _____

Referred by_____Phone_____

Family Physician_____Phone_____

Address_____

PRIMARY INSURANCE

Name of Company_____Phone_____

Address_____

City_____State_____Zip_____

Group # _____Policy #_____

Subscriber's Name_____S.S #._____Date of Birth_____

Referral Required___ Yes____ No Prescription Required ____Yes____No Co-pay____ Yes _____No

SECONDARY INSURANCE

Name of Company_____Phone_____

Address_____

City_____State_____Zip_____

Group # _____Policy #_____

Subscriber's Name_____S.S #._____Date of Birth_____

Referral Required___ Yes____ No Prescription Required____Yes____No Co-pay_____Yes _____No

*******IF MOTOR VEHICLE OR WORKER'S COMPENSATION PLEASE FILL OUT BELOW********

Date of Accident_____ □ Motor vehicle □ Workers' Compensation

Insurance Company_____Adjuster_____Phone_____

Claim#_____ Employer at time of injury_____

□ Motor vehicle---Have you filled out and submitted your PIP application? □Yes □No

□Workers' Compensation—Has your employer filed an accident report? □Yes □No

Attorney's Name_____Phone_____

Attorney's Address_____

Insured's Name (if not the same)_____Phone_____

Insured's Address_____

Have you had treatment elsewhere for this injury? □Yes □No If yes, where?_____

_____

Have you missed any work as a result of this injury □Yes □No If yes, Dates missed from work_____

Date returned to work_____

If you are currently working, is it regular duty or restricted/ light duty? Please describe_____

_____

ASSIGNMENT OF BENEFITS

I irrevocably assign to Spine Center & Orthopedic Rehabilitation of Englewood (Score) all of my rights and benefits under any insurance contracts for payment for services rendered to me by Score. I irrevocably authorize Score to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. I irrevocably authorize Score to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, should sums not be paid within the legally prescribed time frame. In the event that Score elects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I irrevocably assign my rights, title, and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of Score's choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

*****The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to Score upon receipt of the same.***

A photocopy of this agreement shall be valid as the original. This agreement of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Signature_____ Date_____

SPINE CENTER AND ORTHOPEDIC REHABILITATION OF ENGLEWOOD
Phone (201) 503-1900·106· Grand Ave Suite 220, Englewood, NJ 07631 · Fax (201) 503-1901