

WELCOME TO AXIS SPINAL CARE

Today's Date: _____

Last Name: _____ ---- First Name: _____ M.I.: _____

What you prefer to be called: _____ Sex: ---- _____ --

Birthdate: _____ Age: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work Phone: _____

Marital Status: Single: ___ Married: ___ Divorced: ___ Separated: ___ Widowed: - ___

Children: _____ Pregnant? Yes: _____ No: _____ If yes, _____ Months

Spouse's Name (or next of kin): _____ Spouse's Work Phone: _____

Medical Physician's Name: _____

Other Physician's Treating You at This Time: _____

Dominance: Right Handed: ___ Left Handed: ___ Ambidextrous: ___ Email: _____

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- We invite you to discuss with us any question regarding your services. The best health services are based on a friendly, mutual understanding between provider and patient.
 - Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of services and no finance arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
 - I understand the above information and guarantee this term was completed correctly to the best of my knowledge and understanding is my responsibility to inform this office of any changes in my medical status. I hereby authorize assignment of my insurance rights and benefits directly in the provider to services rendered (If offered at this office).

Signature: _____ Date: _____