Port City Neurosurgery & Spine

George A. Alsina, M.D.
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Thomas E. Melin, M.D.

Registration Form

Today's Date: _____ Date of Appt: _____

Reason for visit: _____

REFERRING PHYSICIAN: _____
Full Name Phone #

PATIENT: _____
First Name Middle/Maiden Name Last Name Suffix

Sex
☐M
☐F

Race
☐White/Caucasian
☐Asian
☐Other Race
☐Black/African American
☐American Indian/Alaskan
☐Native Hawaiian or Pacific Islander

Ethnic Origin
☐Hispanic
☐Non-Hispanic

Dominant Hand
☐Right
☐Left

_____
Date of Birth Marital Status Primary Language Spoken Social Security # Age

_____
Street Address/P.O. Box City County State Zip

_____
Home Phone # Work Phone # Cell Phone # Email Address Preferred Contact Method

_____
Employer Employer Address

_____
Spouse's Name Employed by Spouse's Phone #

_____
Nearest Friend or Relative to Contact in Case of Emergency Relationship Phone # Other than Listed Above

PRIMARY INSURANCE: _____
Insurance Company Name Policy Holder Name and Date of Birth

_____
Policy ID # Group # Date of Injury

SECONDARY INSURANCE: _____
Insurance Company Name Policy Holder Name and Date of Birth

_____
Policy ID # Group #

I/we authorize Port City Neurosurgery & Spine, P.C. to release any medical information acquired in the course of patient's examination or treatment and authorize payment of medical and/or surgical benefits directly to the provider named. Port City Neurosurgery & Spine, P.C. may file insurance appeals on my/our behalf. I/we also give Port City Neurosurgery & Spine, P.C. permission to obtain any medical information needed from other sources in the course of patient's treatment or examination. I understand that regardless of any insurance that may be filed on my behalf, I am ultimately responsible for my own bills. It is agreed that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Port City Neurosurgery & Spine, P.C. the cost of reasonable attorney's fees will be added to the outstanding balance. Any outstanding balances on my account over 45 days old may be subject to a 1½ % per month (18% annual) finance charge. Patient and/or Legal Guardian signing below agree to be liable for the payment of the medical services provided for the patient named above.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, which is also available for viewing and printing at www.portcityspine.com.

_____ _____
Witness Signature of Patient or Legal Guardian