



Carolina Neurosurgery & Spine Associates

225 Baldwin Avenue
Charlotte, NC 28204
(704) 376-1605

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS			SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		HOME PHONE	CITY, STATE ZIP		HOME PHONE	
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		CONTACT NAME		CONTACT HOME PHONE
PRIMARY EMPLOYER			SECONDARY EMPLOYER (if Applicable)			
ADDRESS			ADDRESS			
CITY, STATE ZIP			CITY, STATE ZIP			
WORK PHONE			WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		CITY, STATE ZIP			
HOME PHONE		HOME PHONE			
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#			
NAME OF INSURED		GROUP#			
ADDRESS OF INSURANCE COMPANY		COPAY AMT		\$	
CITY, STATE ZIP		DEDUCTIBLE		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#			
NAME OF INSURED		GROUP#			
ADDRESS OF INSURANCE COMPANY		COPAY AMT		\$	
CITY, STATE ZIP		DEDUCTIBLE		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE		EXPIRATION DATE	

FINANCIAL POLICY/AUTHORIZATION TO RELEASE INFORMATION TO PAY

I understand that I am responsible for all medical expenses, regardless of insurance coverage and whether or not there is an accident with another person at fault. I hereby authorize CNSA to release any information acquired in my treatment to the insurance company (ies) listed above. I hereby authorize payment directly to CNSA for treatment. In order to obtain proper authorizations, by signing below I verify that I have presented correct insurance card(s).

SIGNATURE OF PATIENT/GUARDIAN

DATE