Delcalzo
Spine
and Wellness Center

# Patient Information

**Name:** _____ **Date of Birth:** _____
Address: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Male ☐ Female ☐
Cell Phone: _____ **Martial Status**
Email : _____ S M D W

**Preferred method of contact:** Home Number ☐ Work Number ☐ Cell Number ☐ Email ☐

Occupation: _____ Employer: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

**Emergency Contact Name:** _____ Phone: _____

Primary Care Physician: _____ Phone: _____
Address: _____ Permission to Contact Yes ☐ No ☐
Date of last visit _____

**Who referred you to our office?** _____

**Health Insurance Information – Please present all cards and id for copying**
Primary Insurance: _____ Subscriber same as patient Yes ☐ No ☐
Subscriber's Name: _____ Date of Birth: _____
Id / Member Number: _____ Group Number: _____
Secondary Insurance: _____
Subscriber's Name: _____ Date of Birth: _____
Id / Member Number: _____ Group Number: _____

**If accident related:** **Date of Accident** _____
Insurance Name: _____ Subscriber same as patient Yes ☐ No ☐
Subscriber's Name: _____ Policy Number: _____
Adjuster's Name: _____ Claim Number: _____
Phone Number: _____ Adjuster's Fax Number: _____
Attorney's Name: _____ Phone Number: _____
Address _____ City _____ State _____ Zip _____

**Please read and sign the following:**

**Consent to Treat and Authorization of Payment:**
**I the undersigned hereby authorize the Delcalzo Spine and Wellness Center to perform diagnostic tests and to administer treatment as is necessary. I also certify that no guarantee or assurance had been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize my carrier to remit payment directly to this office and I permit this office to endorse remittances as payment toward my account. However, I clearly understand and agree that all services rendered to me are my personal responsibility.**

**Authorization of Release of Records:**
**I understand and agree to allow Delcalzo Spine and Wellness Center to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize Delcalzo Spine and Wellness Center to release all information necessary. I also understand that it is my responsibility to inform Delcalzo Spine and Wellness Center if for any reason there is someone to whom I do not wish to have my records released to.**

**Patient Signature:** _____ **Date:** _____

**Guardian's Signature Authorizing Care** _____ **Date** _____