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PATIENT INFORMATION: FEMALE MALE DATE OF APPT: _____

NAME _____ BIRTHDATE _____
(FIRST) (MIDDLE INITIAL) (LAST) (MONTH) (DAY) (YEAR)

ADDRESS _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

PHONE _____ ALTERNATIVE PHONE _____ S.S.# _____
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

PLEASE CHECK ONE -ARE YOU: EMPLOYED DISABLED RETIRED UNEMPLOYED

PLACE OF EMPLOYMENT _____ PHONE _____

OCCUPATION _____ MARITAL STATUS: SINGLE DIVORCED WIDOWED MARRIED

SPOUSE'S NAME _____ SPOUSE'S SOCIAL SECURITY # _____

SPOUSE'S PLACE OF EMPLOYMENT _____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN _____

NAME FOR EMERGENCY _____ RELATIONSHIP _____ CELL OR WORK # _____

INSURANCE INFORMATION: This information is for billing purposes, please list the name of the company we should bill first, then the second & if there is a 3rd company list the information on the back of this form. (This include Medicare, car accidents, Medicaid & Workers Comp)

PRIMARY INSURANCE CO _____ POLICY NUMBER _____

POLICYHOLDER NAME _____ POLICYHOLDER D.O.B. _____

RELATIONSHIP TO PATIENT _____ GROUP NUMBER: _____

SECONDARY INSURANCE CO _____ POLICY NUMBER _____

POLICYHOLDER NAME _____ POLICYHOLDER D.O.B. _____

RELATIONSHIP TO PATIENT _____ GROUP NUMBER _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please bring your insurance cards to your appointment so we can copy them for our files)

I hereby authorize the providers of Curo Clinic to furnish information to insurance carriers regarding my illness and treatment hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I accept full financial responsibility for any balance on my account.

SIGNED _____ DATE _____

PLEASE NOTE: If the patient is a child, the parent(s) should fill in their own information in the spaces provided for the spouse's information.