

**Spinal & Sports Care Clinic, PS**  
**12905 E. Sprague Ave., Spokane Valley, WA 99216**

Legal Name (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Single  Married  Other

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Patient Employer/School: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

May we leave a phone message if we need to contact you?  Yes  No E-Mail Address: \_\_\_\_\_

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**In Case of Emergency Contact**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

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**Insurance Information**

Who is responsible for this account? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

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**Accident Information**

Is condition due to an accident  Yes  No If yes, date of accident: \_\_\_\_\_

Type of Accident  Auto  Work  Other Reported accident to whom: \_\_\_\_\_

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*I understand it is my responsibility to provide Spinal & Sports Care Clinic with accurate information concerning my insurance coverage and personal information. I understand that all quotes are an estimate and all balances are subject to the information Spinal and Sports Care Clinic received from my insurance carrier. I understand there are no guarantees of benefits and I am financially responsible for all charges rendered whether or not paid by my insurance. I authorize Spinal & Sports Care Clinic the use of my signature on all insurance submissions. I also authorize Spinal & Sports Care Clinic to provide information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services rendered and assign directly to Spinal & Sports Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand Spinal & Sports Care Clinic will not become involved in any dispute between me and my insurance company. It will be my responsibility to settle any such dispute.*

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient/parent/guardian/personal representative

\_\_\_\_\_  
Relationship to Patient