REGENERATIVE SPINE & JOINT CENTER

BORIS TEREBUH, MD
www.RegenerativeSpineAndJoint.com
6860 Perimeter Drive, Suite A
Dublin, Ohio 43016
(614) 389-3089, (614) 389-3876 fax

Demographic Form

How did you hear about us? Doctor (who) ___________________________ Family/Friend (who) _________________________
Internet (which search words) ______________________________________ Search Engine GOOGLE, BING, YAHOO, Other ______
Other source of hearing about us (which) ____

PATIENT INFORMATION

Last Name __________________________ **First Name** ________________________ **Middle Initial** _________

Address ______________________________**City** _____________________ **State** ____**Zip**_________________

Social Security Number______________________ **Date of Birth** ____ / ____/ ____ **Male**____ **Female**____

Home Phone Number (_____) _____________________ **Cell Phone Number** (_____) ____________________

Email Address ____

Marital Status: Never Married___ Married ___ Widowed ___ Divorced ___ **Preferred Language**: English ___ Spanish ___ Other ___
Race: American Indian or Alaskan Native___ Asian___ Black or African American___ Native Hawaiian or other Pacific Islander___
White___ Other ___ Decline to Answer___ **Ethnicity**: Hispanic/ Latino ___ Not Hispanic/ Latino ___ Other ___ Decline to Answer ___

Employer ______________________________________ **Work Phone Number** (____) _________________

Family Doctor's Name __________________________ **Referring Doctor's Name**____________________________

Emergency Contact Person _____________________________________ **PH#(** ______) _______________

Relationship to the Patient_______________________________________

Pharmacy/Location___________________________ **Phone# of Pharmacy**___________________________

Is this condition job/work related? **YES** **NO** Date of onset ___________________ Litigation pending? **YES** **NO**

Is this related to an auto accident? **YES** **NO** Date of onset ___________________ Litigation pending? **YES** **NO**

Is this related to any accident? **YES** **NO** Date of onset ___________________ Litigation pending? **YES** **NO**

PRIMARY MEDICAL INSURANCE INFORMATION

◯ Medicare ◯ Medicaid ◯ CHAMPUS/CHAMPVA ◯ Group Health Plan ◯ Workers' Compensation
Policy Holder Name:____ Policy Holder SS#:________________________
Policy Holder Employer:____ Policy Holder DOB: ________________________
Your Relationship to the Policy Holder: ____

SECONDARY MEDICAL INSURANCE INFORMATION

◯ Medicare ◯ Medicaid ◯ CHAMPUS/CHAMPVA ◯ Group Health Plan ◯ Workers' Compensation
Policy Holder Name:____ Policy Holder SS#:________________________
Policy Holder Employer:____ Policy Holder DOB: ________________________
Your Relationship to the Policy Holder: ____

PATIENT AUTHORIZATION

I hereby authorize my insurance company, BWC, MCO, Medicare, Medicaid, etc. to pay by check (made out and mailed directly to Regenerative Spine & Joint Center) the expense benefits allowable and otherwise payable under my current policy as payment toward the total charges for professional services rendered. I agree to pay in a current manner any balance of said professional service charges over and above this payment within 30 days from the time the service was provided. Additionally, should it be requested, I authorize release of any information concerning my health and health care services to the above noted insurance company, BWC, MCO, Medicare, Medicaid, etc. I also, authorize the release of any information to my referring physician and to my primary care physician.

Signature: ____ Date: _________________________________