Revival Spine Surgery * 621 S. New Ballas Road, Suite 589A, St. Louis, MO 63141

PATIENT INFORMATION

PATIENT NAME_____GOES BY_____

DR._____REV._____MR._____MASTER_____MRS._____MS._____MISS_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____□ texting ok E-MAIL

ADDRESS_____

MAY WE THANK SOMEONE FOR REFERRING YOU ?_____

MALE/FEMALE DATE OF BIRTH__/_____/_____SOCIAL SECURITY #_____-_____-_____

MARITAL STATUS_____EMPLOYER/SCHOOL_____OCCUPATION_____

EMERGENCY CONTACT: NAME _____ RELATIONSHIP _____PHONE _____

PREFERRED LANGUAGE: ENGLISH/SPANISH RACE/ETHNICITY_____

PREFERRED COMMUNICATION METHOD(S): □ EMAIL □ POSTAL □ TELEPHONE □ TEXT

PRIMARY INSURANCE OR RESPONSIBLE PARTY INFORMATION

INSURANCE COMPANY _____ID#_____GROUP#_____

SUBSCRIBER NAME_____□ PATIENT □ SPOUSE/RES PARTY

SUBSCRIVER ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____EMPLOYER_____

SOCIAL SECURITY #_____-_____-_____ MALE/FEMALE DATE OF BIRTH_____/_____/_____

SECONDARY INSURANCE OR RESPONSIBLE PARTY INFORMATION

INSURANCE COMPANY _____ID#_____GROUP#_____

SUBSCRIBER NAME_____□ PATIENT □ SPOUSE/RES PARTY

SUBSCRIVER ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____EMPLOYER_____

SOCIAL SECURITY #___-_____-_____ MALE/FEMALE DATE OF BIRTH_____/_____/_____

OTHER'S WHO MAY ACCESS MY INFORMATION:_____

INJURY: Y/N TYPE: WORKERS COMP/AUTO/OTHER DATE OF INJURY _____

I authorize the release of any medical information necessary to my family or caregivers, referring or family physicians , or to process a claim on any insurance company. I hereby assign to and authorize directly to REVIVAL SPINE SURGERY, LLC all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay my entire bill and I agree to pay the difference or the entire bill if necessary.

I agree that REVIVAL SPINE SURGERY, LLC and/or its agents, in order to service my account or collect monies I may owe, may contact me by telephone at any number associated with my account, including wireless telephone numbers which could incur usage charges. I also agree that I may be contacted through text messages or emails, using any email address I provide. Contact methods may include pre- recorded or artificial voice messages and/or use of automatic dialing devices.

I/we have read this disclosure and agree that REVIVAL SPINE SURGERY, LLC its employees and/or agents may contact me/us as described above.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE