

NORTH BROWARD NEUROSPINAL SURGERY

PATIENT INFORMATION

PLEASE PRINT

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: (____) _____ - _____ Cellphone: (____) _____ - _____ Work: (____) _____ - _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ M _____ F Social Security: _____ - _____ - _____

Race: _____ Ethnicity: *Hispanic/Not Hispanic*

Primary Language: _____ Marital Status: _____

Employer: _____ Work Address: _____

Referring Doctor: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Primary Doctor: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Pharmacy Name: _____ Address: _____ Phone: (____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____ - _____

Is this office visit due to an accident? Yes _____ No _____ Date of Injury: ____/____/____

Please Circle One: Auto Worker's Comp Other _____

If a Car Accident, please provide insurance carrier, policy number, reference number and contact person below:

Attorney Name: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

APPOINTMENT POLICY FOR NORTH BROWARD NEUROSPINAL SURGERY

I _____ (print name) **understand the appointment policy as outlined below.**

North Broward NeuroSpinal Surgery offers appointment times from 9:00 AM to 4:30 PM to accommodate our patients' specific needs. Your appointment time is reserved just for you and scheduled specifically to provide quality medical care during your scheduled visit.

As a courtesy, our staff provides a telephone reminder 1 day before your appointment, providing you with options to confirm and cancel prior to your scheduled time. Our check-out staff will also offer a reminder card with your appointment times listed.

In the event that you must cancel your appointment, we request that you provide our office at minimum 24-hours' notice.

Patient/Guardian Signature

_____/_____/_____
Date

