West Coast Spine Center
Craig L. Barcomb, DC

Patient Information

Name (First, Middle, Last)_____ Date of Birth_____

Billing Address_____ (City,State,Zip):_____

Social Security #_____ Sex: M___ F___ Marital Status: Single___ Married___ Widowed___ Divorced___

Home Phone:_____ Cell Phone:_____ Cell Phone Carrier:_____ Preferred Name:_____

E-Mail: _____ Employment Status: Retired___ Employed___ Student___ Other:_____

Method of Payment

Cash/Check/Credit____ Health Insurance____ Medicare Insurance____ Auto Accident____ Workers Compensation____

Please present a copy of your Insurance Card and Picture Identification.

Consent

Do you give permission for West Coast Spine Center to E-Mail and/or text Appointment and health information to you.

Yes_____ No_____

Person to Contact in Case of an Emergency

Name:_____ Phone:_____ Relationship to Patient:_____

Is Your Illness or Injury Related to Any of the Following?

Employment____ Emergency____ Accident____ Auto Accident ____

How Were You Referred to Our Office?

By an Attorney____ By a Doctor____ By a Patient____ Internet____ Other____

Please print the name of your source_____

Consent to Treatment/Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment. I hereby assign, transfer and set over to West Coast Spine Center all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by Insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person:_____ Date:_____