



SOUTH FLORIDA SPINE INSTITUTE

Spinal Reconstructive Surgery
Cervical, Thoracic, and Lumbar Spine

DAN S. COHEN, M.D.
Board Certified
American Board of Orthopaedic Surgery

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Board Certified
Physiatry and Pain Medicine

PATIENT'S INFORMATION REGISTRATION SHEET
INFORMACION DEL PACIENTE
PLEASE PRINT CLEARLY

PATIENT'S NAME/ Nombre del paciente: _____
LAST/ APELLIDO FIRST/NOMBRE

SOCIAL SECURITY NUMBER/ Numero de seguro social : _____

AGE/ Edad : _____ BIRTH DATE/ Fecha de nacimiento: _____

PERMANENT ADDRESS/ Direccion permanente: _____
Street/ Calle APARTMENT #

CITY/ Ciudad: _____ STATE/ Estado: _____ Zip Code: _____

PERMANENT PHONE/ Telefono permanente: () _____

LOCAL ADDRESS/ Direccion Local : _____

LOCAL PHONE: Telefono Local : () _____ SEX/Sexo : MALE /Masculino ()
FEMALE/ Femenino ()

PATIENT'S OCCUPATION / Ocupacion del paciente: _____

EMPLOYED BY/ Empleo: _____ PHONE/ Tel: () _____

MARITAL STATUS/ Estado Civil (CIRCLE/ Marque) : Single/ Soltero(a) Married/ Casado(a)
Divorced/ Divorciado(a) Widowed/ Viudo(a)

REFERRED BY/ Referido por: _____

RESPONSIBLE PARTY OR SPOUSE/ Persona responsable o esposo(a) : _____

ADDRESS/ Direccion: _____

EMPLOYED BY/ Empleo: _____ PHONE/Telefono: _____

ADDRESS/Direccion: _____

OCCUPATION/ Ocupacion : _____

REASON FOR VISIT: (Circle) AUTO _____ WORKER'S COMPENSATION _____ OTHER _____
Rason por su visita (Marque uno) Accidente de auto _____ accidente de trabajo _____ otro _____

DATE OF ACCIDENT/ DIA DEL ACCIDENTE : _____

EXPLAIN/ Explique: _____

PLEASE TURN OVER & COMPLETE THE OTHER SIDE
(FAVOR DE VIRAR ESTA HOJA Y COMPLETAR OTRO LADO)

**REGISTRATION INSURANCE INFORMATION
INFORMACION DEL SEGURO**

NAME OF FIRST INSURANCE/Nombre del primer seguro: _____

CONTRACT/POLICY/ID NO./ Numero de contrato, poliza o identificacion: _____

GROUP/ GRUPO() PRIVATE/ PRIVADO () GROUP NUMBER/ NO DE GRUPO: _____

INSURANCE ADDRESS/ Direccion del seguro: _____

NAME OF SUBSCRIBER/Nombre del asegurado : _____

RELATION TO PATIENT/ Relacion con el paciente: _____

NAME OF SECONDARY INSURANCE/ Nombre del seguro secundario: _____

CONTRACT/POLICY/ID NO./ Numero de contrato, poliza o identificacion: _____

INSURANCE ADDRESS: _____

GROUP/ GRUPO () PRIVATE/ PRIVADO () GROUP NO/ NO DE GRUPO: _____

NAME OF SUBSCRIBER/ Nombre del asegurado : _____

RELATION TO PATIENT/ Relacion con el paciente: _____

PHYSICIAN RELEASE

I hereby authorize payment of all medical insurance benefits directly to Orthopaedic and Spinal Associates of South Florida, P.A.

I authorize the release of any medical information required by my insurance carrier. A copy of this authorization may be used in lieu of the original.

I understand that I am responsible for charges not covered by this authorization or my insurance coverage. I further understand and agree that should my account be referred to an agency or attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

PATIENT'S SIGNATURE _____ DATE: _____