SHERBAN SPINE INSTITUTE

8190 S. Jog Rd. Ste. 100 Boynton Beach, FL 33472

PHONE: (844) 733-3774

GENERAL INFORMATION

PATIENT NAME : _____

ADDRESS : _____

EMAIL: _____

TELEPHONE : HOME : _____ **CELL :** _____

DATE OF BIRTH : _____ **SEX : MALE :** _____ **FEMALE :** _____

SOCIAL SECURITY NUMBER : _____

CHIEF COMPLAINT: _____

No Fault

Understand that without majority of the below information, you or your back-up insurance may be billed in lieu of missing information about your No Fault claim.

The more information we have, the more timely we are able to process any requests for additional testing, surgery, braces, etc that the physician may/may not wish to order at your appointment. If you are unsure how to obtain the below information, before you arrive at our office, contact your Auto Insurance, they will assist you.

AUTO INSURANCE INFO {for the vehicle you were in at the time of the accident}	
Insurance Company:	
Insurance Company Address:	
Name of Policy Holder:	
Relationship to Policy Holder:	
Policy Number:	
NF Claim Number:	
NF Claim Examiner/Adjuster:	
Examiner/Adjuster Phone #:	
Examiner/Adjuster Fax #:	
Attorney:	
ACCIDENT INFORMATION	
Date of Accident:	
Type of injury sustained:	
Brief Description of how accident occurred:	
Have you been treated by another doctor for this injury please provide name(s):	

I,_____ authorize my physician/Max Comp Billing to release any information pertaining to my auto accident to my insurance (for the duration of my treatment for this incident)

Signature:_____ Date:_____

In the event that the above information is not furnished, the charges will be mailed directly to you.