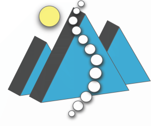

Utah Spine Medicine
Emil Cheng, MD

Patient Information Form

Last Name____________________First Name__________________Middle Initial______Preferred Name________________

Mailing Address___________________________Apt #________City________________________State______Zip__________

Gender_______________ Date of Birth_____________Age________

Marital Status Single Married Partner Divorced Widowed Prefer Not to Say

Mobile Phone_______________________Home Phone_______________________Other Phone_______________________

Preferred Contact Number Mobile Home Other

Email Address (we use a HIPAA-approved Patient Portal)____

Emergency Contact_______________________________Phone____________________Relationship___________________

Referring Provider_________________________________Primary Care Provider___________________________________

Primary Insurance Information

Insurance Carrier____Plan_____________________________________

Group ID (if applicable)________________________________Plan/Member ID_____________________________________

Policy Holder's Name (as printed on card)____

Policy Holder's Date of Birth_________________Relationship to Patient____

Secondary Insurance Information

Insurance Carrier____Plan____________________________________

Group ID (if applicable)_______________________________Plan/Member ID_____________________________________

Policy Holder's Name (as printed on card)____

Policy Holder's Date of Birth________________Relationship to Patient____

Auto or Industrial Insurance Information (if applicable)

Insurance Carrier_______________________________________ Industrial Auto Date of Injury______________

Insurance Address______________________________________City____________________State______Zip___________

Employer (at time of injury)________________________________Claim Number____________________________________

Adjuster Name____Phone_____________________Fax______________________

I have reviewed the "Release of Protected Health Information" and "Financial Agreement" disclosures and by signing this document, as either the patient or patient's authorized representative, accept the terms contained in the disclosures. I also understand that liens on settlements are not an acceptable payment with Dr. Cheng.

____ ______________________

Patient or Patient's Representative Signature **Date**