



Advanced Back Pain & Injury Center
Promoting Pinnacle Lifestyles

ENTRANCE APPLICATION

Welcome! We are honored that you chose us to evaluate your condition, and we feel you are in the right place!
In order for us to better serve you, please fill out the form below completely.
If you need any assistance, feel free to ask our staff.

Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ How Did You Hear About Us? _____

What Is Your Primary Complaint? _____

IS THIS WORKMAN'S COMPENSATION? Y N

IS THIS AN AUTO ACCIDENT? Y N

Birth Date: _____ **Age:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____

Marital Status: S M D W **Spouse's Name:** _____ **# of Children:** _____

Social Security # _____ - _____ - _____ **Driver's License #:** _____

Employment Status: Full Time Part Time Retired Student Unemployed

Occupation: _____ **Employer:** _____ **Insurance?** Y N

Primary Care Physician: _____ **Phone #:** _____

In case of an emergency, whom should we contact? _____ **Relationship:** _____

Cell Phone #: _____ **Alternate Phone #:** _____

INSURANCE INFORMATION

Insured Name: _____ **Insured DOB:** _____ **Insured SS #:** _____ - _____ - _____

Group #: _____ **Policy #:** _____ **Employer Name:** _____

Patient Informed Consent

I, _____ the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and those portions of my body may need to be examined. I understand and consent to clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance, and I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____

Date: _____