ROCKY MOUNTAIN SPINE CLINIC, P.C.

Eric R. Jamrich, M.D. John R. Barker, M.D. Chad J. Prusmack, M.D.

PATIENT INFORMATION

First Name _____ Last Name _____ Birthday _____

Address_____ Apt. #_____ City _____ State_____ Zip _____

Primary Phone #_____ □ Home □ Cell Alternate #: _____ □ Home □ Cell

Email _____ Preferred Method of Contact □ Email □ Phone

Preferred Pharmacy _____ Cross Streets_____ Phone _____

INSURANCE INFORMATION – WE WILL NEED A COPY OF YOUR INSURANCE CARDS EVERY YEAR

Primary Insurance _____ ID# _____ Group# _____

Policy Holder □ Self □ Spouse □ Parent/Guardian Employer _____

Secondary Insurance _____ ID# _____ Group# _____

Policy Holder □ Self □ Spouse □ Parent/Guardian Employer _____

I authorize that payment of any insurance benefits for health care services can be made directly to Rocky Mountain Spine Clinic, P.C.

Note: If patient is a minor under the age of 18 years, these forms must be signed by a parent or legal guardian. They cannot be signed by a minor.

_____ _____

Signature of Patient, Parent or Legal Guardian Date