Terrence L. Piper, M.D.

Christopher Hemmer, N.P

PATIENT REGISTRATION FORM

Do you currently have an active WORKER'S COMPENSATION claim? □ YES □ NO

Does your current condition result from a motor vehicle accident? □ YES □ NO

How did you hear about our practice? _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____

SSN:_____

Home Phone_____ Work Phone: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____ Marital Status:_____

Employer: _____

Employer Address: _____

City, State, Zip: _____

EMERGENCY CONTACT:

Name: _____

Home Phone: _____ Work Phone: _____

112 Piper Hill Dr., Suite 6
St. Peters, MO 63376

P: 636-229-5900
F: 636-229-5920

www.piperspinecare.com

ASSIGNMENT OF MEDICAL BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I authorize Piper Spine Care, P.C. to release any medical information necessary to process insurance claims relating to the medical care provided by its doctors and/or their associates.

I authorize payment of medical benefits to Piper Spine Care, P.C. for any medical care provided to me or to by dependent(s).

I understand that I will be responsible for any balance not covered by my insurance carrier(s).

By my signature, I verify that the information on this form is true and correct as of the date indicated below:

_____ _____

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

112 Piper Hill Dr., Suite 6
St. Peters, MO 63376

P: 636-229-5900
F: 636-229-5920

www.piperspinecare.com