

Cedars-Sinai Institute for Spinal Disorders
Preliminary Patient Appointment/History/Registration Sheet

Completed By _____ Date: _____

Preferred MD _____ Cedars-on-Call _____

Referred by: _____ Specialty: _____

Address: _____

License: _____ UPIN#: _____

Phone#: _____

Patient Name: _____

(Last, First)

Home Address: _____

(City, State Zip)

Home Phone: () _____ Work Phone: () _____

Cell No./Pager: () _____

Email Address: _____ Fax #: () _____

Date of Birth: ____ / ____ / ____ SSN#: ____ - ____ - ____ Sex: Male Female

Marital Status: Married Single Widowed Divorced

Ethnic Group: Caucasian Black Asian Hispanic Native American Other: _____

Religious Preference: _____

Occupation: _____ Employer Name: _____

Employer Address: _____

(City, State Zip)

Employer Ph#: _____ Emergency Contact: _____

Contact Ph# and relation to you: _____

Complaint: _____

Worker's Comp (see page 2) Attorney: _____

Auto Injury Address: _____

Personal Injury Phone #: _____ D.O.I.: _____

Primary Insurance: _____ HMO PPO POS

Insurance Address: _____

Insurance Ph#: _____ Group #: _____ ID#: _____

Effective Date: ____ / ____ / ____ Coverage Code: _____ Subscriber Name: _____

IF Patient is not the subscriber: DOB ____ / ____ / ____ SS# ____ / ____ / ____ of the subscriber

Secondary Insurance: _____ HMO PPO POS

Insurance Address: _____

Insurance Ph#: _____ Group #: _____ ID#: _____

Effective Date: ____ / ____ / ____ Coverage Code: _____ Subscriber Name: _____

Medi-Cal #: _____ Effective Date: _____

Medicare #: _____ Parts B _____ Effective Date: _____ Parts A & B _____

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Films status: _____ Records status: _____

Workers Compensation: (If applies)

Name of Company: _____

Address of Company: _____

Name of Adjuster: _____ Adjuster ph#: _____

Fax #: _____

Claim#: _____ Date of Injury: _____

Name of Employer at time of injury: _____

Address of Employer at time of injury: _____

Phone # of Employer at time of injury: _____

OFFICE USE ONLY

Faxed New Patient packet on _____ Received New Patient packet on _____

Completed New Patient packet sent to Back Office _____

Reviewed by RN on: _____ OK to schedule: _____ Other: _____

Called patient on: _____ Name of employee: _____

Appointment Date/Time: _____

Directions to the Mark Goodson Building

444 South San Vicente Boulevard

From the Santa Monica Freeway:

- 10 to La Cienega Boulevard. exit
- North on La Cienega Boulevard.
- Right on Wilshire Boulevard
- Left on San Vicente Boulevard
- Right on Colgate Avenue

Parking is immediately on your right

