



George A. Alsina, MD
Port City Neurosurgery & Spine

Today's Date: _____

Date of Appt: _____

PATIENT: _____

Last Name

First Name

Middle/Maiden Name

Street Address/P.O. Box _____ City _____ County _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____ Date of Birth _____ Age _____

Sex _____ Social Security # _____ Employer _____ Employer's Address _____

Spouse's Name _____ Employed by _____

Nearest Friend or Relative to Contact in Case of Emergency _____ Relationship _____ Phone # Other than Listed Above _____

PRIMARY INSURANCE: _____

Insurance Company Name

Policy Holder Name and Date of Birth

Insurance Address _____

Policy ID # _____ Group # _____ Date of Injury _____

SECONDARY INSURANCE: _____

Insurance Company Name

Policy Holder Name and Date of Birth

Insurance Address _____

Policy ID # _____ Group # _____

REFERRING PHYSICIAN: _____

Full Name

NPI #

Address _____ Phone # _____ Fax # _____

Reason for visit: _____

I/we authorize Port City Neurosurgery & Spine, P.C. to release any medical information acquired in the course of patient's examination or treatment and authorize payment of medical and/or surgical benefits directly to the provider named. I/we also give Port City Neurosurgery & Spine, P.C. permission to obtain any medical information needed from other sources in the course of patient's treatment or examination. It is agreed that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Port City Neurosurgery & Spine, P.C. the cost of reasonable attorney's fees will be added to the outstanding balance. Any outstanding balances on my account over 45 days old may be subject to a 1½ % per month (18% annual) finance charge. Each of the persons signing below agrees to be liable for the payment of the medical services provided for the patient named above.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices, which is also available for viewing and printing at www.portcityspine.com.

Witness

Signature of Patient or Legal Guardian

1025 Medical Center Dr., Suite 201, Wilmington, NC 28401

www.portcityspine.com