New York Center for Spinal Disorders

Nathaniel L. Tindel, M.D.

PATIENT INFORMATION SHEET

Patient Name:_____ Date of Birth:_____ Age:_____

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

Email:_____ Male/Female Marital Status :_____

Employed Yes/No Occupation:_____ Home Phone: _____

Work Phone:_____ Cell Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

Primary Care Physician:_____ Office Phone:_____

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

Referring MD:_____ Office Phone:_____

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

Is this a work related accident? Yes No (circle one) If so, give date of accident:_____

Is this an auto related accident? Yes No (circle one) If so, give date of accident:_____

Primary Insurance:

Insurance Co:_____ ID#_____ Group#_____

Insured's Name:_____ Insured's Employer:_____

Insured's Date of Birth:_____

Relationship to the Patient:_____

Secondary Insurance: YES/NO Insurance Co:_____ ID#_____

I verify the accuracy of aforementioned information and I authorize the release of information. I also agree to notify Dr. Tindel and/or his office staff of any changes in my insurance coverage or demographics.

X_____ Date:_____

I acknowledge that I have had the opportunity to review and receive a copy of the Notice of Patient Privacy Rights from Dr. Tindel at the time of my visit.

X_____ Date:_____