ERIK C. SPAYDE, M.D.
558 St. Charles Drive, Suite # 200
Thousand Oaks, CA 91360
(805) 379-2322

PATIENT INFORMATION

Last Name:______________________ First Name:__________________ Middle Initial:____________
E-Mail Address:____
Mailing Address:____
City:______________________ State:______________________ Zip:______________________
DOB:______________________ Sex: ☐ Male ☐ Female Age:______________________
Driver's License #:______________________ SS#:______________________ Occupation:______________________
Home Phone:______________________ Work Phone:______________________ Cell Phone:______________________

GUARANTOR INFORMATION (if other than self)

Last Name:______________________ First Name:______________________ Middle Initial:____________
Mailing Address:____
City:______________________ State:______________________ Zip:______________________
DOB:______________________ SS#:______________________ Employer:______________________
Home Phone:______________________ Work Phone:______________________ Cell Phone:______________________

EMPLOYER INFORMATION

Employer Name:____ Phone:______________________
Address:____
City:______________________ State:______________________ Zip:______________________

EMERGENCY CONTACT

Name:____ Phone:______________________

INSURANCE INFORMATION

Primary Insurance:____
Address:____
Subscriber/Policy #:______________________ Group #:______________________
Subscriber Name:______________________ Subscriber DOB:______________________ Subscriber SS#: ______________________

Secondary Insurance:____
Address:____
Subscriber/Policy #:______________________ Group #:______________________
Subscriber Name: ______________________ Subscriber DOB:______________________ Subscriber SS#:______________________

PHYSICIAN & INJURY INFORMATION

Primary Care Physician:____ Phone:______________________
Address:____ Fax: ______________________
Referring Physician:____ Phone: ______________________
Address: ____ Fax:______________________

When did your injury occur or symptoms begin?
Is your injury work related? ☐ Yes ☐ No In relation to an auto accident? ☐ Yes ☐ No

AUTHORIZATION OF BENEFITS AND INFORMATION RELEASE

I hereby authorize that medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize St Charles Spine Institute and my physician to release any information required by my insurance company to process claims.

______________________________ ______________________

Patient/Guarantor Signature Date