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ARK-LA-TEX SPINE CARE

Jefferey D. Adair, MD
Fellowship-trained in Pain Management
Double Board Certified in
Anesthesiology & Pain Management

Last Name:	First:	Middle:
SSN:	DOB:	
Address:	City/State:	Zip:
Mailing Address (check box if same as above) ❑		
Home Number:	Cell Number:	
Race: ❑ Male ❑ Female	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino	
Language: ❑ English ❑ Spanish ❑ Other:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	
Responsible Party (check box if same as above) ❑		
Last Name:	First:	Middle:
Responsible Party's SSN:	DOB:	
Address:	City/State:	Zip:
Contact Number:	Relationship to Patient:	
Employer's Name:	Work Number:	Ext:
In case of an emergency, who may we notify (other than someone living with you):		
Name:	Contact Number:	
Address:	City/State:	Zip:
Who referred you to our office?		
Is your illness/injury due to an auto/work accident? ❑ Yes ❑ No Do you have a lawyer for your illness/injury? ❑ Yes ❑ No - If yes, who?		
Primary Insurance Company:		
Policy Number:	Group Number:	
Employer:	Guarantor:	
Secondary Insurance Company:		
Policy Number:	Group Number:	
Employer:	Guarantor:	
Tertiary Insurance Company:		
Policy Number:	Group Number:	
Employer:	Guarantor:	