COR Spine and Pain Center
6255 Sharlands Avenue • Reno, Nevada 89523
Office: (775)248-1267 Fax: (775)305-1267
Email: contact@corspine.com Website: www.corspine.com

Date: _____ **Appt Date:** _____ **Appt Time:** _____

First Name:	Last Name:
Address:	Apt # or PO Box:
City:	State:
Zip:	Date of Birth:
Home Phone:	Cell Phone:
Work Phone:	Email:

Emergency Contact

First Name:	Last Name:
Phone Number:	Relationship:

Primary Insurance

Insurance:	*Tricare Patients Only: Social Security Number*
Group Number:	ID Number:
Subscriber Information	
Subscriber's Name:	Subscriber's Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:	

Secondary Insurance

Insurance:	
Group Number:	ID Number:
Subscriber Information	
Subscriber's Name:	Subscriber's Date of Birth:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:	

I understand that co-payments are due at the time of visit. I authorize payment of medical benefits from my insurance company to COR Spine and Pain Center. I also authorize the release of any medical information necessary to process any medical claim.

The above is accurate information for this date of service I understand that it is the patients sole responsibly to update any insurance changes to COR Spine and Pain Center at time of service.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____