



Ira Garonzik MD
James Conway MD PHD
Ross Sugar MD
H Christopher Lawson MD

New Patient **Insurance Change** **Address Change**

Appt Date ____ / ____ / ____ **Appt Time** _____

Confidential Patient Information					
First Name	Middle Initial	Last Name	Birth Date	Age	Sex
Address		City	State	Zip Code	
Marital Status			SS #		
Home Phone ()		Work Phone ()		Other Contact Phone ()	
Primary Insurance Information					
Primary Insurance Company		Policy #		Group #	
Primary Policy Holder		Birth Date	SS #	Relationship to Patient	
Secondary Insurance Information					
Secondary Insurance Company		Policy #		Group #	
Secondary Policy Holder		Birth Date	SS #	Relationship to Patient	
Other					
Reason for visit					
Who is your Primary Care Provider?			Phone Number		
Who referred you to our office?			Phone Number		

I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all fees incurred with Baltimore Neurosurgery and Spine Center. I authorize payment of medical benefits to the provider or supplier for all services rendered if the provider of services is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE _____ **DATE** ____ / ____ / ____