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**ACCIDENT RELATED INSURANCE
 WORKERS COMPENSATION, CAR INSURANCE, & OTHER 3RD PARTY LIABILITY**

Please complete this form, if it applies to you. This will allow us to get your claims to the correct persons.
 This form is confidential and will be kept as part of your medical record.
 If you should have any questions about this form, please call our office at (410) 664-3680.

Patient Information					
First Name	Middle Initial	Last Name	Birth Date	Age	Sex
Address			City	State	Zip Code
Home Phone ()		Cell Phone ()		Social Security #	
Employer Name		Employer Phone		E-Mail Address	
Employer Address			City	State	Zip Code
Emergency Contact Person			Emergency Contact Person Phone Number		Relationship to Emergency Contact Person
Pharmacy Name		Pharmacy Address		Pharmacy Phone Number	
Claims Information					
Name of Carrier			Claim #	Date of Injury/Accident	
Billing / Claims Address			City	State	Zip Code
Adjusters Name, if applicable			Phone		
Attorney Information					
Name			Phone	Fax	
Address			City	State	Zip Code
Place of Employment at Time of Injury			Employer Phone Number		
Employer Address			City	State	Zip Code

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** ____/____/____