Mark J. Sontag, M.D.
Sports, Spine and Electrodiagnostic Medicine
Diplomate, Board of Physical Medicine and Rehabilitation
Diplomate, American Association of Neuromuscular & Electrodiagnostic Medicine
Qualified Medical Evaluator

Susan G. Kritzik, M.D.
Physical and Occupational Medicine
Diplomate, Board of Internal Medicine

David F. Smolins, M.D.
Interventional Pain Medicine
Diplomate, American Board of Anesthesiology

Elaine S. Date, M.D.
Musculoskeletal, Spine and Electrodiagnostic Medicine
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Diane Hafner, D.C.

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Patient Information Form (please print)

Name ____
last name first name middle initial

Address ____________________ City ______________ State _____ Zip ________

Phone # Home ______________ Work ______________ Cell ______________ SS # ________

Sex: Male _____ Female _____ Age _____ Birthdate __________ Marital Status: S M Div. Wid.

Current Employer ______________________________ Occupation ______________

Address ____________________ City ______________ State _____ Zip ________

Whom may we thank for referring you? ______________________________

Emergency contact ______________________ Telephone # ______________

Insurance Information (please provide current insurance card)

Insurance Company ____

Address ____________________ City ______________ State _____ Zip ________

Telephone # ______________________ ID # ______________ Group # ________

Name of insured ____________________ SS # ______________ Relationship ________

Secondary Insurance: Yes _____ No _____ Insurance Name ______________________

Workman's Compensation Information

Worker's Comp. Insurance ____

Address ____________________ City ______________ State _____ Zip ________

Employer at the time of injury ______________________________________

Date of injury ____________________ Claim # ______________________

Adjuster Name ______________ Phone # ______________ Ext. # _____ Fax # ________

NCM # ______________ Phone # ______________ Ext. # _____ Fax # ________

Attorney Name ______________________________ Phone # ______________

Assignment and Release

I, the undersigned certify that I have the above named insurance company and assign directly to Dr. Mark Sontag and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ __________
Responsible Party Signature Relationship to Patient Date