Springfield MEDICAL CENTER, P.C.
Back & Neck Pain . Primary Care . Physical Medicine

Dr. Albert Valente
Board Certified Internal Medicine

Dr. Suzanne Lagosky
Certified Physical Medicine & Rehabilitation

Patient Name:____
(Name Must Match Insurance Card) Last First Middle Suffix

Date of Birth:______________________________ **Social Security #** __________-__________-___________

Address:____
Street

____
City State Zip Code

Marital Status:_____________ **E-Mail:** ____

Phone: Home (___) __________________ Work (___) ________________ Cell (____) __________________

Employer: ________________________________ **Occupation**: ______________________________________

Race: ___________________ **Ethnicity**: (Circle One) Hispanic or Non-Hispanic **Language**:________________

Emergency Contact/ Phone/ Relationship: ____

Address of responsible party:____
Street City State Zip Code

Who referred you? ____

INSURANCE INFORMATION

Please provide this information if you are not the primary insured (i.e., your spouse or parent is the policy holder)

Primary Insured Name:____
(Name Must Match Insurance Card) Last First Middle Suffix

Date of Birth:______________________________

I give my consent to receive voicemails regarding my labs/appointments/test results at the phone number(s) listed above: yes_____ no______(initial)

PREFFERED PHARMACY INFORMATION

Pharmacy Number: (Please Provide)____

Is this visit a worker's compensation claim or auto accident? YES or NO
(If yes, prior authorization is required before treatment)

The information I have given is true to the best of my knowledge and I have read and understood the general office guidelines.

Signature:______________________________________ **Date:**______________