SUNSHINE SPINE & PAIN, P.A.

ARKAM REHMAN, M.D. / LISA TANNER, ARNP
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Physical Medicine & Rehabilitation / Interventional Spine Practice

2021 Kingsley Ave, Suite 103
Orange Park, FL 32073

14540 St. Augustine Rd, Suite 2397
Jacksonville, FL 32258

3 Shircliff Way Suite 610 (Dillon Bldg.)
Jacksonville, FL 32204

3599 University Blvd. South Suite 405
Jacksonville, FL 32217

PLEASE PRINT PATIENT INFORMATION: DATE______________________

NAME ____ Male____ Female ____
Last first middle
SS# _____________________ Date of Birth ________________ Cell Phone __________________________

Address: ____ Home Ph ________________________
Street address
City / State / Zip ____
Mailing Address (if Different) ____

Referring Physician _________________________________ **Primary Care Physician** ________________________

Place of Employment _______________________________________
Please Check Single______ Married _______ Divorced _______ Widow _______ Dependent ______________

If Married Spouse Name ____
Spouse SS# ____________________________________ **DOB**: ____

Emergency Contact________________________________ Relationship __________________ Phone ___________

I give authorization for medical information, lab work results and other test results to be given to the following:
PATIENT ONLY _________ EMERGENCY CONTACT ________________ OTHER _____________________

I give authorization for messages to be left on my answering machine for:
Test results Or prescription information ________ yes No _______

INSURANCE * PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARDS AND PICTURE ID*****

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Insurance________________________	Name of Insurance_____________________________
Policy/ID# ______________________________	Policy/ID # __________________________________
Group # _________________________________	Group # ______________________________________
Subscriber Name __________________________	Subscriber Name ______________________________
Subscriber DOB___________________________	Subscriber DOB _______________________________
Relationship to Patient _____________________	Relationship to Patient _________________________
AUTO INSURANCE * If applicable**	**WORKER'S COMPENSATION**
Name of Insurance__________________________	Name of Insurance_____________________________
Claim # __________________________________	Claim #_______________________________________
Claims Address ____________________________	Claims Address _______________________________
____	____
Date of Accident___________________________	Date of Injury ________________________________
Contact Name ______________________________	Case Manager _________________________________
Contact Phone # ___________________________	Contact Phone # _______________________________