

# SOUTH SHORE NEUROSPINE GROUP, LLC



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www.ssneuro.com

FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY OR TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE HOME: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_

GENDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

PRIMARY CARE PROVIDER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

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PRIMARY INSURANCE: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ COPAY: \_\_\_\_\_

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SECONDARY INSURANCE: \_\_\_\_\_ POLICY ID: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ COPAY: \_\_\_\_\_

WORKERS COMPENSATION  AUTO ACCIDENT

If work related or related to an auto accident, you will be given another form to fill out.

## IMPORTANT REFERRAL NOTICE

If you have health insurance that requires referrals from your primary care provider for services by a specialist, it is your responsibility to provide this office with a referral for all services.

I authorize the release of all medical information necessary to process insurance claims for my services.  
I also authorize payment of medical benefits directly to South Shore NeuroSpine Group, LLC.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name