

BUFFALO SPINE SURGERY, PLLC
ANDREW CAPPUCCINO, MD
46 DAVISON COURT
LOCKPORT, NY 14094
PHONE (716) 438-2973
FAX (716) 438-9267

Date: _____

Name: _____ Birthdate: _____ Age: _____ Sex M F

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) () _____ (Work) () _____ (Mobile) () _____ Marital Status S M D Sep W

SS # _____ - _____ - _____

Employer _____ Occupation: _____

Employer's Address: (Street) _____ City: _____ State: _____ Zip: _____

Primary Physician: _____ Phone: () _____

Address: (Street) _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: () _____

Address: (Street) _____ City: _____ State: _____ Zip: _____

Emergency Contact: Name _____ Phone: (Home) () _____ (Work) () _____

INSURANCE INFORMATION

(Workers' Compensation, No Fault, see additional items below)

Circle One: BC/BS WNY Community Blue IHA Univera Medicare Other _____

ID # _____ Group # _____ Plan # _____

Subscriber Name: _____ Co-pay Required yes no uncertain

Subscriber SS# _____ Subscriber DOB _____ Employer _____

SECONDARY INSURANCE

Insurance Name: _____ Phone # () _____

Address: (Street) _____ City: _____ State: _____ Zip: _____

ID # _____ Group # _____ Plan # _____

Subscriber Name: _____ Co-pay Required yes no uncertain

Subscriber SS # _____ Subscriber DOB _____ Employer _____

NO - FAULT

Date of Accident: _____

Insurance Name: _____ Phone # () _____

Address: (Street) _____ City: _____ State: _____ Zip: _____

No Fault Policy Number: _____ Claim # _____

Claim Representative: _____

WORKERS' COMPENSATION

Is the reason for your visit related to your employment? YES NO If yes - please complete additional sheet