

**Westchester Spine and Brain Surgery, PLLC**  
**280 North Central Ave., Suite 235**  
**Hartsdale, N.Y. 10530**  
**www.wsbsonline.com**  
TEL 914-332-0396  
FAX 914-468-8895

Dr. Deborah Benzil, M.D. \_\_\_\_\_  
Dr. Bennie W. Chiles III, M.D. \_\_\_\_\_

Visit Date \_\_\_\_\_

**PART I-PATIENT INFORMATION (Please Print)**

**Patient Name** \_\_\_\_\_  
First Middle Last

Reason for visit \_\_\_\_\_

Sex (M/F) \_\_\_\_ Age \_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Drivers license#/State \_\_\_\_\_

**Phone numbers** \_\_\_\_\_  
Home Work Cell /pager

**Street address (if different or PO Box written above) –**

Street name and house/apt number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Employer** \_\_\_\_\_  
Name

Address City State Zip

**Referring Physician**

**Primary Care Physician**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

**Patient Mother's name** \_\_\_\_\_ **Patient Father's name** \_\_\_\_\_  
First, MI, Last First, MI, Last

**Emergency contact** \_\_\_\_\_  
Name Daytime Phone number Relationship to pt

Street address City State Zip

## PART II- INSURANCE INFORMATION

### Accident/ injury claims:

Is the reason for this visit due to any type of accident or injury? Y \_\_\_ N \_\_\_

**\*If no, please skip this section and go to Health Insurance Information section at bottom of page.**

If yes, please explain cause of accident, date, and location of accident, and provide information requested below:

---



---

### **Workers Compensation/Auto accident claims:**

**Please indicate type of accident: Workers Compensation \_\_\_ No Fault (Auto) \_\_\_**

Date of injury \_\_\_\_\_ Please indicate part of body injured \_\_\_\_\_

Insurance company name \_\_\_\_\_

Claims address/city/state/zip \_\_\_\_\_

Insurance co. phone # and contact name \_\_\_\_\_

Claim or file # \_\_\_\_\_ Is this claim active? \_\_\_\_\_

Policyholder \_\_\_\_\_ Relation to patient \_\_\_\_\_

Attorney name, address and phone # \_\_\_\_\_

---

Are you currently working? Y \_\_\_ N \_\_\_ If no, please indicate last day worked \_\_\_\_\_

### **For No-fault (Auto) claims only—Were you the:**

Automobile Driver \_\_\_ Passenger \_\_\_ Pedestrian \_\_\_ Bicyclist \_\_\_ Motorcyclist \_\_\_

Motorcycle passenger \_\_\_ Other (specify) \_\_\_\_\_

### **For Workers Compensation claims only:**

Employer responsible for injury \_\_\_\_\_

Responsible employer address/ph# \_\_\_\_\_

Your job title or duties at time of injury \_\_\_\_\_

## **HEALTH INSURANCE INFORMATION (please provide ID card(s) for copying)**

**Primary Insurance** Check one: HMO \_\_\_ PPO \_\_\_ Medicare \_\_\_ Other \_\_\_\_\_

Insurance Co. name \_\_\_\_\_ Referral required? \_\_\_ Effective date \_\_\_\_\_

Insurance company claims address \_\_\_\_\_

---

Insurance co. phone number \_\_\_\_\_ Office Co-pay amount (if applicable) \_\_\_\_\_

Identification/policy # \_\_\_\_\_ Group/plan# \_\_\_\_\_

**Subscriber information:**

Name \_\_\_\_\_ Sex \_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_

Social Security # \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address (if different than patient) \_\_\_\_\_

Phone # (if different than patient) \_\_\_\_\_ Employer \_\_\_\_\_

Employer address \_\_\_\_\_

Work Phone# \_\_\_\_\_

**SECONDARY INSURANCE**    Check one: HMO \_\_ PPO\_\_ Medicare \_\_\_\_ Other \_\_\_\_

Insurance Co. name \_\_\_\_\_ Referral required? \_\_\_\_\_ Effective date \_\_\_\_\_

Insurance Co. claims address \_\_\_\_\_

---

Insurance Co. phone # \_\_\_\_\_ Office copay amount (if applicable) \_\_\_\_\_

Identification/policy # \_\_\_\_\_ Group/plan # \_\_\_\_\_

**Subscriber information:**

Name \_\_\_\_\_ Sex \_\_\_\_ Date of birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security # \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (if different than patient) \_\_\_\_\_

Phone # (if different than patient) \_\_\_\_\_ Employer name \_\_\_\_\_

Employer address \_\_\_\_\_

Work phone # \_\_\_\_\_

**Other information you would like to provide:** \_\_\_\_\_

---

**Thank you for your cooperation.**