Donald S. Soloniuk, M.D.

324 5th Street, Ste. 101 - Lewiston, ID 83501

Patient's name _____ Sex: M or F

Patient's Date of Birth _____ Social Security # _____

Mailing Address _____

Home phone _____

Employer & employer phone _____

Spouse/Guardian _____ DOB _____

Contact Person / Phone _____

Referring Physician / Phone _____

Family Physician / Phone _____

Cardiologist – Practice Location/Phone _____

INSURANCE / BILLING INFORMATION

Person to be billed _____ Relationship _____

Insurance Carrier _____ Phone _____

Insurance Address _____

Policy Number _____ Group Number _____

Is this an accident or work related injury? _____ If so, Date of injury _____

Employer at time of injury if work related _____

If not work related, where did injury occur? _____

Assignment of Benefits: "I hereby authorize payment to be made directly to Donald S. Soloniuk, MD and/or Neurosurgery & Spine Care Specialists, T. William Hill, MD and/or Clearwater Neurosurgery & Spinal Surgery Associates of all benefits payable to me under the terms of my insurance policy with respect to professional services provided."

"All information written is true and given to the best of my ability."

Signature _____ Date _____