



**CONFIDENTIAL  
HEALTH INFORMATION**

All information you supply is confidential. We  
comply with all federal privacy standards.

**Advanced Back Solutions**  
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Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Marital Status    Single    Married    Divorced    Separated    Widowed

Address : \_\_\_\_\_ Apt# \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:    Cell Phone    Home Phone    Email    Text

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Insurance Carrier : \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Birth Date : \_\_\_\_\_

Insured's Address : \_\_\_\_\_

Who carries this policy?    Self    Spouse    Parent

Secondary Insurance Carrier : \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Birth Date : \_\_\_\_\_

Insured's Address : \_\_\_\_\_

Who carries this policy?    Self    Spouse    Parent