

**PATIENT INFORMATION SHEET (Please print)
COMPREHENSIVE PAIN MANAGEMENT**

Full Name _____ Date of Birth _____ Male
First Middle Last _____ Female

Address _____
Street Apt # City State Zip

Social Security Number _____ Home Phone (____) _____ Marital Status _____

Email Address: _____

Employment: Company Name _____ Work Phone _____

Address _____

Occupation: _____

Cell Phone (____) _____ County in which you live _____

Name of Spouse _____ Social Security # _____ Date of Birth _____

Employed By: _____ Work Phone _____

Address _____

Individual to contact in an emergency: _____

(List someone who does not live with you) First Middle Last
Relationship to patient _____ Home Phone _____ Work Phone _____

Have you seen Pain Management before? _____ If so physicians name _____ Phone _____

Who referred you to our office? _____ Phone _____

Who is your primary care physician? _____ Phone _____

INSURANCE INFORMATION			Do you have a co-pay? YES NO		Amount _____
Insurance Company	Card/Policy	Policy Number	Group	Subscribers	Type of Coverage
Name	Holder/Name		Number	Social Security #	Primary Secondary Tertiary

Name of Card Holder's Employer _____ Phone Number _____

Patient's relationship to Card/Policy Holder or Subscriber of Insurance _____

Is the reason for your visit related to an injury? YES NO Date of Injury _____

How did the injury happen? _____

Name of Treating Physician _____ Phone Number _____

Last date worked _____ Date of Disability _____ FULL PARTIAL

Is the reason for your visit related to an **ON THE JOB** injury? YES NO An **AUTOMOBILE** accident YES NO

Please give us the name and phone of the person at your employment who can verify this information and approve your visit today.

Name _____ Phone Number _____

INSURANCE INFORMATION:

Case Manager/Agent _____ Claim Number _____

Company: _____ Phone Number _____

Address _____

Assignment of Benefit/Consent for Treatment do hereby assign all medical and /or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I authorize this office to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means; including, but not limited to Medicare. I hereby voluntarily consent to my treatment at this office and authorize such treatment, examination, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results which may be obtained by such treatments and procedures hereby affirmed by the signature of the undersigned.

PATIENT SIGNATURE: _____ **DATE:** _____