

PAIN RELIEF CENTERS

PATIENT INFORMATION

Name (please print):		Gender: M / F
SS#:	Date of Birth:	Marital Status:
Phone: ()	Email:	
Street Address:		
City, State, Zip:		
Emergency Contact (Name/Relationship):		
Street Address:		
City, State, Zip:	Phone: ()	
Person Responsible for Payment (Name/Relationship):		
Street Address:		
City, State, Zip:	Phone: ()	
Employer Name:		
Employer Street Address:		Occupation:
City, State, Zip:	Phone: ()	
Referring Physician:		
Primary Care Physician:		Phone: ()
Were you injured on the job (Workers Comp)? yes / no		
Date of Injury:		Phone: ()
Were you injured in an accident?	yes / no	Date of Accident:
Was an automobile involved?	yes / no	Are benefits exhausted? yes / no
Do you have an Attorney?	yes / no	Attorney Name:
Contact person:	Phone: ()	
Primary Insurance Company:		
Policy/Claim#:	Group #	
Claims Address:		
Phone:		
Subscriber Name/Relationship:		
Secondary Insurance Company:		
Policy/Claim #:	Group #	
Claims Address:		
Phone:		
Subscriber Name/Relationship:		

All co-pays and deductibles are due at the time of service. Insurance is filed as a courtesy only. Patients are ultimately responsible for any and all charges that insurance does not pay. A 24-hour notice must be given for all cancelled appointments or you could be charged a fee.

Signature: _____ Date: _____

