

PAIN MANAGEMENT & INJURY RELIEF MEDICAL CENTER

Date: _____ (PLEASE PRINT) Home Phone: (____) _____

Patient: _____ Cell Phone: (____) _____
Last Name First Name Middle Initial

Responsible Party (If a minor): _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth date: _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer _____

Occupation: _____ Employer Phone: (____) _____

Spouse (or responsible party) Employed by: _____

Business Address: _____

_____ Business Phone: (____) _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? No Yes, If yes,

Name of Primary Insurer: _____

Contract# _____ Group# _____ Subscriber# _____

Name of Secondary Insure (if any): _____

Contract# _____ Group# _____ Subscriber# _____

In case of emergency, who should be notified? _____ Phone: (____) _____

Your Drugstore Name: _____ Phone: (____) _____

How did you hear of our practice? _____

Referring Physician: _____ Yellow Page Internet

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the above insurance carrier(s) and hereby authorize Pain Management & Injury Relief Medical Center to release to the carrier(s) any information that is necessary to obtain insurance benefits. I assign to Pain Management & Injury Relief Medical Center all insurance payments for medical services rendered. I understand that I am financially responsible for all charges incurred, whether or not paid by insurance. I acknowledge that I have received a copy of Notice of Privacy Practices of Pain Management & Injury Relief Medical Center.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date