COMPREHENSIVE PAIN MANAGEMENT

PATIENT INFORMATION

Name ____________________

Address ____________________

City/State/Zip ____________________

Home Telephone # ____________________

Sex: ____________________

Date of Birth ____________________

Social Security # ____________________

Occupation ____________________

Employer ____________________

Work Telephone # ____________________

Primary Care Physician ____________________

Name of nearest relative not living with you ____________________

____

Referred By ____________________

Telephone # ____________________

GUARANTOR INFORMATION (Person responsible for medical bills)

Name ____________________

Address ____________________

City/State/Zip ____________________

Home Telephone # ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent ☐ Grandparent

Social Security # ____________________

Employer ____________________

Work Telephone # ____________________

PRIMARY INSURANCE INFORMATION

Ins. Co. Name ____________ Copay ______

Address ____________________

City/State/Zip ____________________

Telephone # ____________________

Subscriber Name ____________________

Policy # ____________________

Group # ____________________

Effective Date ____________________

Date of Birth ____________________

Social Security # ____________________

SECONDARY INSURANCE INFORMATION

Ins. Co. Name ____________________

Address ____________________

City/State/Zip ____________________

Telephone # ____________________

Subscriber Name ____________________

Policy # ____________________

Group # ____________________

Relationship to Patient ____________________

Date of Birth ____________________

Social Security # ____________________

OTHER INSURANCE INFORMATION

Is this visit related to:

☐ Work Related Injury __________ ☐ Auto Accident __________ ☐ Personal Injury __________

Ins. Co. Name ____________________

Address ____________________

City/State/Zip ____________________

Ins. Co. Telephone # ____________________

Name of Adjuster ____________________

Name of Attorney ____________________

Date of Injury ____________________

State Injury Occurred ____________________

Claim # ____________________

Accident Description ____________________

____

Attorney Telephone # ____________________

Is this claim active? ____ yes ____ no

EMERGENCY INFORMATION

Emergency Contact____________________________ Relationship ________________________________

Home Telephone # ____________________________ Work Telephone #_____________________________

Patient Information

I hereby authorize Comprehensive Pain Management to release information acquired during the course of my examination & treatment to the Health Care Financing Administration & its agents, or any other third-party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare directly to Comprehensive Pain Management. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature ___________________________________ Date ____