Please Print Clearly

Last Name___________________ First ___________________Date of Birth_________Age___ Sex__

Address____City________________ Zip __________

Home Phone(_____)______________Cell Phone(_____)________________SS# _________________

Marital Status ____________________________Spouse's Name ______________________________

Emergency Contact_______________________Relation________________Phone________________

Employer___________________ Occupation___________________Work Phone_________________

Referring Physician_________________________ Phone_________________Fax_______________

Address______________________________________City____________________ Zip ___________

Pharmacy_________________________ City_________________ Phone # ______________________

Where can we obtain radiology records?____

If you have your insurance card, you can present it to our staff and skip this section.

Primary Insurance______________________Group Name_______________ID #_________________

Guarantor's Name____________________Date of Birth______________SS#____________________

Relationship to patient (self, spouse, child, other)____

Secondary Insurance______________________ID #__________________Group#________________

- **Release**: I certify the above is complete and correct. Authorization is hereby given to Pain Medicine Specialty Group to release to my insurance company/health plan any information acquired during the course of my examination and treatment that is deemed necessary to adjudicate a claim. I authorize my insurance/health plan to pay benefits directly to Pain Medicine Specialty Group, Inc.
- I also understand I am financially responsible for any services or charges not covered by my insurance/health plan.

Signature of Patient or Legal Representative____

Date_________________________**Relationship to Patient**__________________________________