INTERVENTIONAL
PAIN INSTITUTE

Patient Information Sheet

Name:____________ Social Security #:____________
Address:____________ Sex: M F Date of Birth:____________
City:____________ State:______ Zip:______ Phone:____________
Email:____________ Spouse Name:____________
Employer Name:____________ Employer Phone:____________
Emergency Contact:____________ Phone:____________
Marital Status: MARRIED SINGLE DIVORCED (circle one)
Race choices: AMERICAN INDIAN ASIAN BLACK NATIVE AMERICAN WHITE UNKNOWN (circle all that apply)
Ethnicity choices: HISPANIC NON-HISPANIC UNKNOWN (circle one)
Language choice:____________

If Minor: Parent(s) or Legal Guardian Name:____________
Address (if different from above):____________
City:____________ State:______ Zip:______
Home phone:____________ cell: ____________

MEDICAL INSURANCE INFORMATION:

1. Will you be filing today's visit through your personal health insurance? Y N *If so, present card to front desk.*
2. Is this a job related injury? Y N *If so, complete section II below.*
3. Is your visit part of a legal, disability or liability related issue? Y N *If so, complete section III below.*

I. REFFERED BY:

Name: ____________ Primary Doctor? Y N

II. WORKMAN'S COMPENSATION CLAIMS: (complete if your visit is result of work related injury)

Date of Injury/Accident: ____________ Did you report this to employer? Y N
Employer:____________ Work Comp Contact Person:____________
Contact Person Phone: ____________
Employer Address: ____________ City:____________ State:______ Zip:______
Work Comp Ins Carrier:____________ Phone:____________
Claim Number:____________ Adjuster:____________

III. Legal/Disability/Liability CIAIMS: (complete if your visit is result of legal,disability or liability issue)

Date of Injury/Accident: ____________
Law Office/Disability/Liability office name: ____________
Lawyer/Agent Name: ____________ Phone: ____________
Address: ____________ City:____________ State: ______ Zip:______

I agree that interventional pain institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I hereby authorize Interventional Pain Institute to release any medical information and/or medical records maintained at this clinic as needed to my insurance company, to the social security administration of carriers, to my attorney listed above, or to the attorney responsible for the payment for medical services or evaluation to be provided. I permit a copy of this authorization to be used in place of the original. I hereby assign to the facility listed above all insurance or Medicare reimbursements for medical and/or surgical expenses. Regulations pertaining to Medicare assignment of benefits apply. I have been given a copy of Notice or Private Practices of Interventional Pain Institute, LLC.

Signature of Patient or Responsible Party: ____________ Date: ____________

Name of Person Completing Form (print): ____________ Relationship to Patient: ____________