INTERVENTIONAL PAIN INSTITUTE
Diagnosis & Treatment of Spine, Cancer and Chronic Pain

Patient Information Sheet

Name: _____

Social Security #: _____

Mailing Address: _____

City/State/Zip Code: _____

Physical Address: _____

City/State/Zip Code: _____

Sex: (Circle One): **Male Female** **Date of Birth**: _____

Phone Number: _____ (Circle One): Home Work Cell

Secondary Phone Number: _____ (Circle One): Home Work Cell

Email Address: _____

Employer: _____ **Employer Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____

Marital Status: (Circle One): **Married Single Divorced Widowed**

Spouse Name: _____

Race Choices:(Circle All That Apply): American Indian Asian Black Native American White Unknown

Ethnicity Choices: (Circle One): Hispanic Non-Hispanic Unknown

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? (Circle One) **YES NO** *If YES, present insurance card to front desk.*
2. Is this a job-related injury? (Circle one) **YES NO** *If YES complete section II below.*
3. Is your visit part of a legal, disability or liability related issue? (Circle one) **YES NO** *If YES complete section III below.*

I. Referred By:

Name: _____ Primary Doctor? YES NO

II. Workman's Compensation Claims: *(complete if your visit is a result of a work-related injury)*

Date of Injury/Accident: _____ Did you report this to your employer?
(Circle One): **YES NO**

Employer: _____

Employer Address: _____

Workers Comp Contact Person: _____

Contact Person Phone: _____

Work Comp Insurance Carrier: _____ Claim Number: _____

Adjuster: _____ Phone: _____

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

Date of Injury/Accident: _____

Law Office/Disability/Liability Office Name: _____

Lawyer/Agent Name: _____

Paralegal: _____

Phone: _____ Email: _____

Address: _____

IV. Do you have a cardiologist? (Circle One): YES NO

If yes, name and phone number: _____

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: _____

Printed Name: _____ Date: _____

Name of Person Completing Form (if other than patient): _____

Relationship to Patient: _____