physicianpaincare

Insurance Information

ALL PATIENTS MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING A PHYSICIAN.

LAST NAME _____ FIRST NAME _____MIDDLE INITIAL _____

ADDRESS _____

CITY _____STATE_____ ZIP _____

PHONE (H) _____PHONE (C) _____PHONE (W) _____

BIRTHDATE _____ **SEX** M F MARITAL STATUS _____

SSN _____ EMAIL ADDRESS _____

PRIMARY CARE PHYSICIAN _____WHO REFERRED YOU TO US? _____

EMERGENCY CONTACT _____PHONE NUMBER _____

PRIMARY INSURANCE COMPANY: _____

ID/SUBSCRIBER NUMBER: _____

Policy Holder: _____Policy Holder's Date of Birth: _____

SECONDARY INSURANCE COMPANY: _____

ID/SUBSCRIBER NUMBER: _____

Policy Holder: _____Policy Holder's Date of Birth: _____

I acknowledge and agree that payment for services rendered is due at the time of service. Any applicable co-payments or deductible amounts are due at the time of service. I authorize payment of benefits to Physician Pain Management, for services rendered under the terms of my insurance policy. I authorize Physician Pain Management to release any medical information necessary to process insurance claims. I understand that I am responsible for any balances that are unpaid or denied by my insurance carrier. I also understand that by giving you the above phone numbers, I am giving you authority to leave messages for me or about my care at these numbers unless otherwise indicated by me on this form.

_____ _____

Signature Printed name

_____

Date