PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

Patient Information

Name: ______________________________ Date: __________

Date of Birth: __________ Sex: ☐ M ☐ F SSN: ______________________

Street Address: ____

City: ______________________ State: __________ Zip Code: __________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________

Work Phone: (   ) ______________ Email: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other: ______________

Primary Language: ☐ English ☐ Spanish ☐ Other: ______________________

Race: ______________________ Ethnicity: ______________________

Primary Care Provider: ______________________ PCP Phone: (   ) ______________

Referring Provider: ______________________ Referring Phone: (   ) ______________

Emergency Contact Information

Contact Name: ______________________ Relation: ______________________

Phone Number: (   ) ______________ Alternate Number: (   ) ______________

Pharmacy Information

Pharmacy Name: ______________________ Pharmacy Phone: (   ) ______________

Pharmacy Address: ____

Employment Information

Employer: ______________________ Employer Phone: (   ) ______________

Occupation: ______________________ Status: ☐ Full Time ☐ Part Time ☐ Retired

Injury Information

☐ Work Injury ☐ Auto Accident Date of Injury: __________

Company: ______________________ Claim Number: ______________

Contact Person: ______________________ Contact Phone: (   ) ______________

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Name: ____ Date of Birth: ___________

Insurance Information

Primary Insurance: ____ Copay: __________

Policy Number: _____________________ Group Number: __________________________

Policy Holder's Name: ____

Policy Holder's Date of Birth: ________________ Policy Holder's SSN: _________________

Policy Holder's Street Address: ____

City: ______________________________ State: ___________ Zip Code: ______________

Policy Holder's Phone: (   ) ______________ Relation to Patient: __________________

Policy Holder's Employer: ___________________ Employer Phone: (   ) ______________

Secondary Insurance: ______________________________________ Copay: __________

Policy Number: _____________________ Group Number: __________________________

Policy Holder's Name: ____

Policy Holder's Date of Birth: ________________ Policy Holder's SSN: _________________

Policy Holder's Street Address: ____

City: ______________________________ State: ___________ Zip Code: ______________

Policy Holder's Phone: (   ) ______________ Relation to Patient: __________________

Policy Holder's Employer: ___________________ Employer Phone: (   ) ______________

Consent for Insurance Payment & Financial Responsibilities Acknowledgement

I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I authorize the assignment of benefits and payments, including Medicare, private insurance, and other health plans, directly to Premier Pain Treatment Institute for all of my insurance claims related to services received. It is my responsibility to pay any co-pay, deductible, co-insurance, denied charges, and non-covered services. I agree to pay any and all charges that exceed or are not covered by my insurance. I permit a copy of this authorization to be used in place of the original. This authorization will remain in place effect from the date of signing until it is revoked by me in writing.

Signature of Patient/Guardian: _________________________________ Date: ____________