PAIN MANAGEMENT CENTER OF IRVINE

4902 Irvine Center Drive, Suite 201, Irvine, CA 92604-3335
p: (949) 857-4712 f: (949) 857-4797

W E L C O M E

Patient Information Date:_____/_____/_____

Name: _____
Last First MI

MailingAddress:_____State_____Zip_____

Email Address: _____@_____

Phone # (H)_____(W)_____(Cell)_____

Can we call you at work? YES NO

Date of Birth: _____/_____/_____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation:_____Employer:_____

Employer Address: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone: _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other

Has it been reported? Yes No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (Insured Patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Pain Management Center Of Irvine, Inc, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____**DATE** _____/_____/_____