Valley Pain Specialists, P.C.

Please fill out all information that applies, if it does not apply, please put N/A

Name			Home Phone#	Work Phone#
Address		Cell Phone #		
		DOB		
SS#	Gender: ☐ Male ☐ Female	Spouse's DOB		
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Emergency Contact or Spouse		Phone:		

Referring Physician:	Phone & Address:
PCP/Family Physician:	Phone & Address:
Pharmacy:	Phone & Address:

Primary Insurance Personal Coverage		**Secondary Insurance Personal Coverage**	
Company Name		Company Name	
Policy #/ID / Group#		Policy #/ID / Group#	
Name of subscriber		Name of Subscriber	
Subscriber SS#	Subscriber DOB	Subscriber SS#	Subscriber DOB

Fill out this block if your medical expenses will be covered by Worker's Compensation or Auto Insurance	
Insurance Company	**Claim/Policy #**
Phone #	Address:
Date/Area of Injury:	Case Manager
Employers Name	**Employers Telephone**
Attorneys Name	**Attorney's telephone**

I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered. I hereby consent treatment for myself, my child, or the above mentioned minor, for whom I accept responsibility. The release of medical information to any insurance carrier and direct payment to Valley Pain Specialists, P.C. for treatment or examination rendered is authorized.

Please Sign ____

Signature of Patient or Guardian Date

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Pain Specialists, P.C., for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Please Sign ____

Signature of Patient or Guardian Date