



**COMPREHENSIVE  
PAIN CENTERS**

TODAY'S DATE \_\_\_\_\_

**PATIENT INFORMATION**

**NAME** \_\_\_\_\_

ADDRESS \_\_\_\_\_

SEX \_\_\_\_\_ E-mail address \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

SOC. SEC. # \_\_\_\_\_

OCCUPATION \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

FULL TIME STUDENT?  YES  NO

ARE YOU DISABLED? YES NO

**PERSON TO NOTIFY IN EMERGENCY:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE ( ) \_\_\_\_\_

RELATION \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? – (Circle One)**

ADVERTISEMENT? TV Radio Internet  
Word of Mouth Doctor Referral

OTHER \_\_\_\_\_

**FAMILY PHYSICIAN:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

**REFERRING PHYSICIAN:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

**FAMILY PHYSICIAN:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

**I AM HERE TODAY FOR TREATMENT**

**RELATED TO:**

( ) WORK INJURY – DATE \_\_\_\_\_

( ) AUTO ACCIDENT – DATE \_\_\_\_\_

( ) OTHER \_\_\_\_\_

**PATIENTS EMPLOYER**

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

CONTACT \_\_\_\_\_

**INSURANCE INFORMATION – PLEASE FILL IN APPLICABLE INFORMATION**

**BLUE SHIELD**

I.D.# \_\_\_\_\_

GROUP # \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SUB. DATE OF BIRTH \_\_\_\_\_

SOC. SEC. # \_\_\_\_\_

**MEDICARE**

I.D. # \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

DO YOU HAVE 65 SPECIAL?  YES  NO

IF YES I.D. # \_\_\_\_\_

GROUP # \_\_\_\_\_

**WORKER'S COMPENSATION**

INS. CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

CLAIM # \_\_\_\_\_

ADJUSTER \_\_\_\_\_

HAS INJURY BEEN REPORTED TO YOUR

EMPLOYER?  YES  NO

**OTHER/AUTO/MEDICAL ASSISTANCE**

COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

POLICY # \_\_\_\_\_

GROUP # \_\_\_\_\_

CLAIM/FILE # \_\_\_\_\_

CONTACT \_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO COMPREHENSIVE PAIN CENTERS (CPC) FOR ANY SERVICES FURNISHED ME BY CPC. 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. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO CPC FOR ANY AMOUNT NOT COVERED BY THIS AUTHORIZATION. I WILL BE NOTIFIED WHEN FINAL ACTION (REJECTION, ETC.) BY MY INSURANCE CARRIER HAS BEEN RECEIVED BY CPC. PAYMENT WILL BE EXPECTED WITHIN 10 DAYS OF THAT NOTICE. IN THE EVENT THAT THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR COLLECTION AGENCY, THE UNDERSIGNED IS RESPONSIBLE FOR COLLECTION FEES, REASONABLE ATTORNEY'S FEES AND COURT COSTS.

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_