UNIVERSITY Pain Clinic

Patient Information Sheet

NAME (last, first, middle)	HOME PHONE	WORK/CELL PHONE (circle)

DATE OF BIRTH	AGE	SS#	OCCUPATION	DRIVERS LICENSE #

ADDRESS	CITY	STATE	ZIP CODE

MARITAL STATUS (circle one)	Single	Married	Divorced	Widowed	Separated	Student	Other

REFERRING PHYSICIAN (name and address)	REFERRING PHYSICIAN PHONE #
PRIMARY CARE PHYSICIAN (name and address)	PRIMARY CARE PHYSICIAN PHONE #

Question			
A. Are you employed?	______ Yes	______ No	Please provide date of accident/injury below.
B. If yes, do you receive health care benefits from employers plan?	______ Yes	______ No	
C. Does this plan pay before Medicare?	______ Yes	______ No	
D. Is your condition a result of an accident or personal injury?	______ Yes	______ No	
E. Is your condition covered under a Workman's Comp claim?	______ Yes	______ No	

IF YOU ANSWERED YES TO D OR E, PLEASE PROVIDE INFORMATION IN BOX BELOW.

INSURANCE COMPANY NAME	CLAIM ADJUSTER NAME	CLAIM #	INS. PHONE #
INSURANCE ADDRESS	CITY	STATE	ZIP

ARE YOU INVOLVED IN A PAIN-RELATED LEGAL CASE? ____________ YES ___________ NO. IF YES, PLEASE PROVIDE:

NAME OF ATTORNEY		ATTORNEY'S PHONE #	
ATTORNEY ADDRESS	CITY	STATE	ZIP
NAME OF EMPLOYER	POSITION (title)	EMPLOYER TELEPHONE #	
EMPLOYER ADDRESS	CITY	STATE	ZIP
NAME OF RESPONSIBLE PARTY	SS#	HOME PHONE AND ALTERNATE PHONE #	
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP
PERSON TO CONTACT IN AN EMERGENCY	EMERGENCY CONTACT #	RELATIONSHIP	
EMERGENCY CONTACT ADDRESS	CITY	STATE	ZIP

PRIMARY INSURANCE INFORMATION _______ Group/Medical ______Workers Comp _______ Auto

INSURANCE COMPANY NAME	TELEPHONE #	EFFECTIVE DATE	
INSURANCE ADDRESS	CITY	STATE	ZIP
OWNER OF INSURANCE POLICY (last, middle, first, middle)	RELATIONSHIP	INS. ID #	GROUP #

SECONDARY INSURANCE INFORMATION ___ Group/Medical ______Workers Comp _______ Auto

INSURANCE COMPANY NAME	TELEPHONE #	EFFECTIVE DATE	
INSURANCE ADDRESS	CITY	STATE	ZIP
OWNER OF INSURANCE POLICY (Last, First, Middle)	RELATIONSHIP	INS. ID#	GROUP #

I hereby authorize University Pain Clinic to release to my insurance company any information acquired in the course of my examination or treatment that is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the physician/clinic any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility.

Signed: ____ Date: ____________________________