

# WELCOME TO PAIN SPECIALISTS OF TEXAS!

## PATIENT INFORMATION:

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
SOC. SEC # \_\_\_\_\_ SEX F M  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
REFERRING DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_ REASON \_\_\_\_\_

## RESPONSIBLE PARTY:

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC # \_\_\_\_\_  
RELATIONSHIP TO PT \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## INSURANCE PRIMARY

CARRIER NAME \_\_\_\_\_ TYPE \_\_\_\_\_ INSURANCE PHONE \_\_\_\_\_  
CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
INSURED NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
SOC. SEC # \_\_\_\_\_ EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
SUBSCRIBER ID \_\_\_\_\_ GROUP ID \_\_\_\_\_ REFERRAL NEEDED Y N  
REFERRAL # GIVEN \_\_\_\_\_ FOR HOW MANY VISITS \_\_\_\_\_

## INSURANCE SECONDARY

CARRIER NAME \_\_\_\_\_ TYPE \_\_\_\_\_ INSURANCE PHONE \_\_\_\_\_  
CARRIER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
INSURED NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
SOC. SEC # \_\_\_\_\_ EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
SUBSCRIBER ID \_\_\_\_\_ GROUP ID \_\_\_\_\_ REFERRAL NEEDED Y N  
REFERRAL # GIVEN \_\_\_\_\_ FOR HOW MANY VISITS \_\_\_\_\_

## EMERGENCY CONTACT

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

## ASSIGNMENT AND RELEASE:

I HEREBY AUTHORIZE ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME TO BE PAID DIRECTLY TO  
**PAIN SPECIALISTS OF TEXAS**. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR  
NOT INSURANCE PAYS AND FOR ALL SERVICES RENDERED TO MY DEPENDENTS

I ALSO AUTHORIZE **PAIN SPECIALISTS OF TEXAS** TO RELEASE INFORMATION TO SECURE PAYMENTS ON MY BEHALF.  
I AUTHORIZE THE USE OF MY SIGNATURE TO BE USED ON ALL INSURANCE FORMS.

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF AUTHORIZED PARTY, IF NOT PATIENT \_\_\_\_\_ DATE \_\_\_\_\_