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**_____