The Pain Intervention Center

Patrick H. Waring, M.D., LLC

Name: (Mr. Ms. Mrs.) _____ (Jr. Sr.)
Last First Middle

Social Security # _____ Date of _____ Age _____

Marital Status: Single / Married Gender: M / F

_____
Street Address City State/Zip

_____
Cell Phone# Home Phone# Work Phone#

Email Address_____

Emergency Primary Contact & Phone _____

Emergency Secondary Contact & Phone_____

THE FOLLOWING INFORMATION MUST BE COMPLETED FOR FEDERAL GUIDELINES
Race: _____ Ethnicity: _____Language: _____
Hispanic / Non-Hispanic English/Spanish/Italian, etc.

Referring Physician: _____ Primary Care Physician:_____

Preferred Pharmacy for prescriptions:

_____
Name Location Phone/Fax

Drug Allergies:_____

Do you use tobacco products: Current/ Former/ Never

What type of tobacco use? _____ How long?____
When did you stop?_____

Have you retained an attorney? Yes/No

Attorney Name: _____ Phone #_____

I understand that if I have retained an attorney for my injury/accident that the attorney will be responsible for payment and necessary procedures. The insurance companies are now deferring payment to the responsible third party.

Patient Signature: _____ date:_____

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