PAIN
INTERVENTION
CENTER

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

Social Security # _____ **Date of Birth** _____ **Age** _____

Marital Status: Single / Married **Gender:** M / F

_____
Street Address **City** **State / Zip**

_____
Cell Phone # **Home Phone #** **Work Phone #**

Email Address _____

Emergency Primary Contact _____
Name Phone

Emergency Secondary Contact _____
Name Phone

THE FOLLOWING INFORMATION MUST BE COMPLETED FOR FEDERAL GUIDELINES

Race _____ **Ethnicity** _____ **Language** _____
Hispanic / Non-Hispanic English / Spanish / French, 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** _____