Advanced Interventional Pain Consultants

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | First: | | | | | | Middle: | | | | | | | | | | | | Marital status: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single  Mar  Div  Sep  Wid | | | | | | | | | | | | | |
| Is this your legal name? | | | | | If not, what is your legal name? | | | | | | | | | | | | (Former name): | | | | | | | | | | | | Date of Birth: | | | | | | | | Age: | Sex: | | | | |
| Yes | | No | | |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |  | M | | | F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | Home phone no.: | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | ( ) | | | | | | | | |
| P.O. box: | | | | | | | | | City: | | | | | | | | | | | | | | | | | State: | | | | | | | | | | ZIP Code: | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Occupation: | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | |
| Chose clinic because/referred to clinic by (Please check one box): | | | | | | | | | | | | | | | | | | | Dr. | | | | |  | | | | | | | | | | | Insurance plan | | | | | Hospital | | |
| Family | | | Friend | | | Close to home/work | | | | | | | | | | | Yellow Pages | | | | | | | | | Other | | | | | |  | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | |  | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | Birth date: | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | |
|  | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | |
| Is this person a patient here? | | | | | | | Yes | | | | | | | No |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | |
|  | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | |
| Subscriber’s name: | | | | | | | | Subscriber’s S.S. no: | | | | | | | | | | Birth date: | | | | | | | Group no.: | | | | | | | | Policy no.: | | | | | | Co-payment: | | | |
|  | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | $ | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | Self | | | | Spouse | | | | | Child | | | | Other | | | | |  | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | Home phone no: | | | | | | | | | Work phone no.: | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | ( ) | | | | | | | | | ( ) | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required processing my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | |  |

Jaime Robledo MD