

Date Info Taken:

ADVANCED PAIN CENTERS, S.C.

Provider:

NAME (LAST, FIRST, MIDDLE)			MALE/FEMALE	HOME PHONE	WORK PHONE
DATE OF BIRTH	AGE	SS#		DRIVER'S LICENSE #	
ADDRESS			CITY	STATE	ZIP CODE
NAME OF PATIENT EMPLOYER			OCCUPATION	EMPLOYER TELEPHONE #	
PATIENT EMPLOYER NAME, ADDRESS			CITY	STATE	ZIP CODE
EMPLOYMENT STATUS: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Retired <input type="checkbox"/> Student- <input type="checkbox"/> Full <input type="checkbox"/> Part Time					
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Student				EMAIL:	
13. ARE YOU EMPLOYED?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
14. IF YES, DO YOU RECEIVE HEALTH CARE BENEFITS FROM EMPLOYERS PLAN?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
15. DOES THIS PLAN PAY YOU BEFORE MEDICARE?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
16. IS YOUR CONDITION A RESULT OF AN ACCIDENT OR PERSONAL INJURY?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE OF ACCIDENT/INJURY
17. IS YOUR CONDITION COVERED UNDER A WORKMEN'S COMP CLAIM ?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	16. _____ 17. _____
IF YOUR CONDITION IS A RESULT OF A WORKERS COMP/ACCIDENT/PERSONAL INJURY PLEASE PROVIDE:					
CLAIM ADJUSTER NAME		CLAIM #		TELEPHONE #	
NATURE OF INJURY					
ARE YOU INVOLVED IN A PAIN RELATED LEGAL CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES,					
NAME OF ATTORNEY			TELEPHONE #		
ATTORNEY ADDRESS			CITY	STATE	ZIP CODE
PRIMARY INSURANCE INFORMATION <input type="checkbox"/> GROUP/ MEDICAL <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO					
INSURANCE COMPANY NAME			TELEPHONE#	EFFECTIVE DATE	
INSURANCE ADDRESS			CITY	STATE	ZIP CODE
OWNER OF INS POLICY (LAST, FIRST, MIDDLE)		SS#	DOB	INS ID #	GROUP #
SUBSCRIBER'S EMPLOYER			EMPLOYER PHONE	RELATIONSHIP	
EMPLOYER ADDRESS			CITY	STATE	ZIP CODE
SECONDARY INSURANCE INFORMATION <input type="checkbox"/> GROUP/ MEDICAL <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO					
INSURANCE COMPANY NAME			TELEPHONE#	EFFECTIVE DATE	
INSURANCE ADDRESS			CITY	STATE	ZIP CODE
OWNER OF INS POLICY (LAST, FIRST, MIDDLE)		SS#	DOB	INS ID #	GROUP #
SUBSCRIBER'S EMPLOYER			EMPLOYER PHONE	RELATIONSHIP	
EMPLOYER ADDRESS			CITY	STATE	ZIP CODE

ADVANCED PAIN CENTERS, S.C.

PERSON TO CONTACT IN AN EMERGENCY	EMERGENCY CONTACT PHONE #	RELATIONSHIP	
EMERGENCY CONTACT ADDRESS	CITY	STATE	ZIP CODE
REFERRING PHYSICIAN NAME		REFERRING PHYSICIAN PHONE	
ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE PHYSICIAN NAME		PRIMARY CARE PHYSICIAN PHONE	
ADDRESS	CITY	STATE	ZIP CODE

I hereby authorize Advanced Pain Centers, SC to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the Physician any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility. **IF ANY OF THE ABOVE INFORMATION IS INACCURATE OR INCOMPLETE AND THIS CAUSES MY CLAIMS TO BE UNPROCESSABLE OR DENIED, I UNDERSTAND THAT THE UNPAID BALANCES ARE MY RESPONSIBILITY.**

SIGNED _____ DATE _____

SCHEDULING INFORMATION

DATE OF APPOINTMENT	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	OFFICE LOCATION <input type="checkbox"/> HOFFMAN ESTATES <input type="checkbox"/> WESTMONT	TYPE OF APPOINTMENT
PROCEDURE SCHEDULED	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	PROCEDURE LOCATION <input type="checkbox"/> HF <input type="checkbox"/> PC <input type="checkbox"/> AB <input type="checkbox"/> HH <input type="checkbox"/> HP <input type="checkbox"/> ES <input type="checkbox"/> OTHER _____	
REASON FOR REFERRAL	PLEASE BRING <input type="checkbox"/> MRI FILMS & REPORT <input type="checkbox"/> CT SCAN FILMS & REPORT <input type="checkbox"/> X-RAY FILMS <input type="checkbox"/> MYELOGRAM FILMS & REPORT		

VISIT HAS BEEN PRE-CERTIFIED PROCEDURE HAS BEEN PRE-CERTIFIED REFERRAL OBTAINED

SIGNATURE OF PRE-CERT: _____ DATE: _____

NEW PATIENT PACKET SENT REFERRING PHYSICIAN INFO RECEIVED

SELF PAY FEE \$ _____ # OF INSTALLMENTS _____ DUE DATES _____

GUARANTEE OF PAYMENT ALREADY OBTAINED MUST BE OBTAINED

SPECIAL COMMENTS: