Comprehensive Rehabilitation & Pain Specialists, P.C.

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PATIENT INFORMATION

Patient Name: ______________________ DOB: ______________________ Date: ____________

Address: ______________________ City ____________ State ____________ Zip ________

Home phone #: ______________________ Cell #: ______________________ Social Security #: ____________

Primary Language Spoken: ______________________ Race: ______________________

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

State of License: ______________________ Primary Care Physician: ______________________

Driver License #: ______________________ Referring Physician: ______________________

Employer's Name & Address: ______________________ Employer Phone #: ______________________

Email: ______________________ Married Single Divorced Widowed

Spouse's Name: ______________________ Social Security #: ______________________

Spouse's Employer: ______________________ Employer's Phone #: ______________________

Spouse's Employer Address: ______________________

Does the patient have health insurance? ☐ Yes ☐ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: ___________________________ ID#______________________________________

Secondary Insurance Carrier:___________________________ ID#______________________________________

Subscriber's relationship to patient (wife, husband, etc.):________________ Subscriber DOB: ______________________
Subscriber's Gender:__________________Subscriber SSN:________________ Subscriber I.D. # ______________________
I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Comprehensive Rehabilitation & Pain Specialists.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature shall be as valid as the original.

Patient Signature: ______________________

Witness Signature: ______________________

Emergency Contact: ______________________

Phone #: ______________________ Cell #: ______________________ Relationship: ______________________