COLUMBUS PAIN CENTER

DEMOGRAPHIC INFORMATION

Name _____

Date of Birth _____ Age _____ SSN _____

Mailing Address _____

Physical Address _____

Phone # (____) _____ Work # (____) _____ Cell # (____)_____

Alternate Contact information _____ Phone Number (____)_____

Please provide the name of someone who does not live with you we may contact in case of emergency
Name _____Relationship _____ Phone (____)_____

Student Employed Retired Marital Status Single Married Widowed Other

If employed, please list employer name and address _____

_____

REFERRAL INFORMATION

Please provide the name and address of the physician who referred you to our office: _____

_____

If you were not referred by your physician, how did you hear about our office? _____

HEALTH INSURANCE

Primary Insurance Company _____

Policy Number _____Group Number _____

Please provide the primary policy holders information:
Name _____Date of Birth _____ SSN _____
Address _____

Secondary Insurance Carrier _____

Policy Number _____ Group Number _____

Please provide the secondary policy holders information:

Name _____Date of Birth _____ SSN _____
Address _____

I understand that I am solely responsible for the costs of treatment incurred and am solely responsible for providing information concerning my insurance coverage. I also hereby assign benefit payment to, and allow Columbus Pain Center to provide all information necessary to my insurance carriers.

Patient Signature _____ Date _____