



Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please complete and give to receptionist with your insurance cards.

**PATIENT INFORMATION**

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Age	Birth Date / /	Sex M or F	Occupation
Street Address	City	State	Zip	Social Security #	Home Phone # ( )	Cell Phone # ( )	
Referring Physician	Referring Physician Phone # ( )	Primary Care Physician	Primary Care Physician Phone # ( )				
Pharmacy Name	Pharmacy Phone # ( )	Employer Phone # ( )					
Emergency Contact Name	Relationship	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )			

**INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST)**

<b>Primary Insurance</b>	ID # (include prefix or suffix)	Group #	Plan #
Insurance Carrier Address	Relationship to Subscriber (ie. spouse, parent)		
Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer
<b>Secondary Insurance</b>	ID # (include prefix or suffix)	Group #	Plan #
Insurance Carrier Address	Relationship to Subscriber (ie. spouse, parent)		
Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer

**WORKERS COMPENSATION INFORMATION** if you have more than one active workers compensation claim please complete the information for each separately below

<b>Date of Injury</b>	Insurance Carrier	Employer
WCB #	Carrier Case #	Case Worker Name and Phone Number
Insurance Carrier Address	City	State Zip Apportionment (office use only)
<b>Second Date of Injury</b>	Insurance Carrier	Employer
WCB #	Carrier Case #	Case Worker Name and Phone Number
Insurance Carrier Address	City	State Zip Apportionment (office use only)

**NO FAULT INFORMATION**

Date of MVA	Insurance Carrier	No Fault Claim #
Insurance Carrier Address	City	State Zip
Adjuster Name and Number		

I authorize release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to the ~~New York Pain Center~~ for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above named patient. Failure to give 24 hour notice of cancellation of a NCS/EMG study or a procedure or no-showing for a NCS/EMG study or a procedure will result in a charge of \$50.00 per occurrence. This charge cannot be billed to the insurance company. It will be my responsibility.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_