Patient Information
PLEASE PRINT

Today's date_____ Allergies _____

First name_____ Middle Initial___ Last name_____ DOB _____Age___
Address _____ City _____ State _____ Zip_____
Home number (___)_____ Alternate number ( )_____
Employer _____ Work number _____
Social Security # _____

Referring Physician _____ Office number _____
Primary Care Physician_____Office number _____

Primary Insurance Information
Primary Insurance _____Certificate/ID # _____
Subscribers name _____ Group # _____
Subscribers Employer _____Date of birth _____

Secondary Insurance Information
Secondary/Supplemental Insurance _____Certificate/ID # _____
Subscribers name _____ Group # _____
Subscribers Employer _____ Date of birth _____

IN CASE OF EMERGENCY: 2 relatives NOT living with you
Name _____ Name _____
Phone ( ) _____ Phone ( ) _____
Relationship _____ Relationship _____

Is this a work related injury _____ Explain _____

Automobile Accident _____Date of injury _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Northland Pain Consultants to release the medical information necessary to process a claim for insurance benefits. A copy of this authorization shall be considered as valid as the original.

DATE_____ PATIENT'S SIGNATURE _____

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment directly to Northland Pain Consultants or the individual and/group, hospital, basic, and major medical benefits as submitted by Northland Pain Consultants. I/We understand that I/We are financially responsible to Northland Pain Consultants for charges not covered by this authorization. A copy of this authorization shall be considered as valid as the original.

DATE_____ PATIENT'S SIGNATURE _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Northland Pain Consultants for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and information needed to determine these benefits payable for related services.

_____ _____
SIGNATURE OF MEDICARE PATIENT MEDICARE NUMBER

_____ _____
DATE SIGNED YOUR TIE IN PLAN