CAPS PAINCARE

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Today's Date: ____/____/____ Referred By: __________________

Name: ______________________________ Social Security#: ____ - ____ - ______

Date of Birth: ____/____/_______ Age: _____ Sex: Male _____ Female _____

Address: ____City:____________________St: _____Zip:_______

Home Phone: (_____) _________________ Work Phone: (____) __________________

Emergency Contact: ______________________________ Phone: (____) __________________

Employer: ____

Employer's Address: _________________________________City: ____________________St: _____Zip:_______

Name of Primary Doctor: ______________________________ Doctor's Phone#: (____) _______________

Primary Doctor's Address: ____

INSURANCE INFORMATION

Insurance Company Name: _________________________Insurance Phone# (____) __________________

Insured's Name: _________________________________ Date of Birth: ____/____/_______

Insured ID/SS: __________________________________Insurance Group#: _______________________

Insured's Employer: ____

Insured's Employer Address: _________________________________City: ____________________St: _____Zip:_______

Secondary Insurance Company: _____________________ Insurance Phone# (____) __________________

Insured's Name: _________________________________ Date of Birth: ____/____/_______

Claim# for Work/Auto Injury/Accident: _______________ Date of Accident/Injury: _____/______/______

CONSENT TO RECEIVE MEDICAL TREATMENT

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by the provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees, and/or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

I understand that the doctor's appointment time is valuable; therefore, I authorize the doctor/office to charge me $85.00 for all missed appointments when 24-hour advance cancellation notice is not given to the doctor/office. Additionally, I authorize the doctor/office to charge any past due balance (i.e. more than 90 days past due) to my credit card (if provided by one).

____ ____________________________________

Patient /Guardian Signature **Date**