WELCOME

Today's Date: _____

Patient Demographics

Name: _____
First MI Last Preferred Name

SS#: _____Date of Birth:_____ Gender: ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip _____

Physical Address: ☐ Same as mailing or Street:_____ City: _____ State: ____ Zip _____

Phone# (H) _____ (C) _____ EMAIL_____

(this is for billing purposes only)

Race: ☐ Caucasian ☐ African American ☐ American Indian ☐ Asian ☐ Other: _____

Ethnicity: ☐ non-Hispanic ☐ Hispanic/ Latino ☐ Do not wish to answer Preferred language: ☐ English ☐ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Primary Physician: _____ Referred by: _____

Pharmacy:_____ Pharmacy phone: _____

Emergency contact: Name: _____ Phone #: _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other Date of Injury? _____

Insurance Information ***(must be filled out completely or else you may be responsible for all payments)

WE CANNOT FILE YOUR INSURANCE IF THIS SECTION IS LEFT INCOMPLETE. THE BILL WILL BE SENT TO YOU.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICNESE.

Employer:_____

Primary Insurance: _____ Policy #: _____ Group #:_____

Subscriber: _____ Subscriber DOB: _____ Relation: _____

Secondary Insurance: _____ Policy #: _____ Group #:_____

Subscriber: _____ Subscriber DOB: _____ Relation: _____

Assignment, Consent of Care and Release

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that it is my responsibility to know what my insurance policy will cover, what my co-pays are and amount of deductibles owed. I understand that any charges that my insurance does not pay for will be my responsibility. I understand that I have the right to request specific codes that may or may not be covered that are used by PRI and my insurance company for internal billing procedures. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. I authorize W. C. VanNess, III, MD, dba The Pain & Rehab Institute, to bill and appeal denials on my behalf.

PATIENT SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

If Minor: Please have parent/guardian complete consent form for treatment if patient is allowed to come without parent/guardian.