ADVOCATE PAIN MANAGEMENT CENTER

Thank you for selecting our healthcare team! To provide you with the best possible health care, we will need some information from you. Please take a few minutes to complete these patient information forms. All information is strictly confidential and will be kept in your chart. Please ask one of our staff memebers if you require any help completing the forms.

PATIENT INFORMATION

Date: _____ Patient Name: _____ Home Phone: _____

Alternate Phone: _____

SSN#: _____ ☐Male ☐Female Birthdate: _____

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

Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Other _____

Patient's employer: _____ Work Phone: _____

Occupation: _____

Spouse's name: _____ Work Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

AUTHORIZATION & RELEASE

My signature below indicates that I have reviewed a copy of Advocate Pain Management Center's Notice of Privacy Practices.

By signing below, I authorize release of any of my (or my child's) medical information necessary to process this claim or to coordinate my health care. I permit a copy of this authorization to be used in place of the original.

By signing below, I hereby authorize Advocate Pain Management Center to apply for benefits on my behalf for covered medical services rendered by their medical staff. I request that payment from my insurance company be made directly to Advocate Pain Management Center.

By signing below, I certify that the information I have reported in this patient information form is correct.

_____ _____

(SIGNATURE) (DATE)

If signed by a legal representative, state the name of the representative and relationship to the patient:

_____ _____

(NAME- PLEASE PRINT CLEARLY) (RELATIONSHIP TO PATIENT)