Southern Idaho Pain Institute

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BOARD CERTIFIED ANESTHESIOLOGIST

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PLEASE HAVE INSURANCE CARD & IDENTIFICATION CARD AVAILABLE TO BE COPIED FOR OUR RECORDS

TODAY'S DATE: _____/_____/______ ☐ UPDATE ☐ NEW PATIENT AGE TODAY:______________

PATIENT'S NAME:			GENDER: ☐ F ☐ M
FIRST	MIDDLE	LAST	
DATE OF BIRTH:	S.S#	MARITAL STATUS: S M D W	
HOME#:	CELL#:	WORK#:	
MAILING ADDRESS:	PHYSICAL ADDRESS:		
CITY:	STATE:	ZIP CODE:	

DO YOU CURRENTLY RESIDE IN A NURSING CARE FACILITY? ☐ **YES** ☐ **NO IF YES, WHERE?**_____________________

PREFERRED LANGUAGE: ____________________________**EMAIL**: ____

PATIENT'S EMPLOYER: ______________________________OCCUPATION: ____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED ☐ STUDENT

WHO REFERRED YOU TO OUR PRACTICE: _________________________PRIMARY PHYSICIAN_______________________

EMERGENCY CONTACT_________________________PHONE#:_________________RELATION:____________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ WEBSITE ☐ PROVIDER ☐ FRIEND ☐ OTHER

AUTHORIZATION TO LEAVE INFORMATION ON VOICEMAIL OR ANSWERING MACHINE ☐ **YES** ☐ **NO**

DO YOU HAVE A MEDICAL POWER OF ATTORNEY: YES OR NO WHO: _______________________________________

DO YOU HAVE AN ADVANCED DIRECTIVE: YES OR NO **RACE**: ______________________________________

ETHNICITY: _________________________________

SPOUSE'S NAME: ____

SPOUSE'S EMPLOYER: ______________________________ SPOUSE'S PHONE #:________________________________

SPOUSE'S S.S___________________________________ SPOUSE'S BIRTH DATE: _____________________________

INSURANCE INFORMATION:

IS YOUR VISIT ACCIDENT RELATED? YES OR NO IF YES, DO YOU HAVE AN ATTORNEY? YES OR NO

IF YOU HAVE AN ATTORNEY, WHO IS YOUR ATTORNEY? ___________________________PHONE #: ____________________

WHO WAS YOUR EMPLOYER AT THE TIME OF YOUR WORK RELATED ACCIDENT? _____________________________

PRIMARY INSURANCE:	ID#:	GROUP#:
POLICY HOLDER'S NAME:		
SECONDARY INSURANCE :	ID#:	GROUP#:
POLICY HOLDER'S NAME:		

PHARMACY: ____PHONE: _________________________________

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY: YES OR NO

TODAY I WILL BE PAYING BY: ☐ VISA ☐ MC ☐ DISCOVER ☐ AMERICAN EXPRESS ☐ CASH ☐ CHECK

AUTHORIZATION AND CONSENT TO TREAT/FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THE PHYSICIANS OF THIS OFFICE AND THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT RELEASE OF INFORMATION PERTAINING TO MY TREATMENT FOR INSURANCES PURPOSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE TO SUPPLY ALL NECESSARY INFORMATION, SUCH AS INSURANCE INFORMATION, AUTHORIZATIONS, AND REFERRALS, SO THAT MY INSURANCE CAN BE PROPERLY FILED. I FURTHER AGREE TO PAY ALL COLLECTIONS COSTS, REASONABLE ATTORNEY FEES, AND OTHER COLLECTIONS COSTS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNTS OUTSTANDING.

SIGNATURE:____DATE: ______/______/________