SOUTHERN IDAHO PAIN INSTITUTE
Improving Quality of Life

176 Falls Avenue
Twin Falls ID 83301
Phone 208.733.3181
Fax 208.733.3168

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.

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SIGNATURE:_____

_____/_____/_____