Florida Pain Center
of Naples

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American Board of Anesthesiology, Certification in Pain Management
Board Certified American Board of Pain Medicine

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

BIRTH DATE: ____/____/____ SEX: M ____ F ____ MARITAL STATUS: M___ S___ D___ W___

SSN#: _____ DL#: _____

LOCAL ADDRESS: _____

LOCAL PHONE: _____ CELL PHONE: _____ ALT #: _____

NORTHERN ADDRESS: _____ PH #: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ PHONE: _____

SPOUSE/GUARDIAN NAME: _____ PHONE: _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

REFERRING PHYSICAIN: _____ PRIMARY: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID#: _____ GRP#: _____

POLICY HOLDER (IF DIFFERENT FROM ABOVE): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN #: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ ID# _____ GRP# _____

POLICY HOLDER (IF DIFFERENT FROM ABOVE): _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ SSN #: _____

IS THIS VISIT RELATED TO ___WORMANS COMPENSATION, ___ACCIDENT, OR ___MOTOR VEHICLE CLAIM? __Y __N

NAME OF COMPANY: _____ DATE OF INJURY: _____ CLAIM #: _____

PRESCRIPTION PLAN

INS COMPANY: _____ ID #: _____ GRP #: _____

ASSIGNMENT OF BENEFITS: I authorize the release of any medical records necessary to process any claims I may incur and assign Florida Pain Center of Naples (aka First Anesthesia Associates), all benefits otherwise payable to me for any services rendered to me. I agree that I am financially responsible for any non-covered services, deductibles or co-payments.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICE

I have received a copy of Florida Pain Center of Naples Privacy Policy. I have had the opportunity to have any questions answered regarding the privacy practices of the office.

SIGNATURE: _____ DATE: _____

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