NEW PATIENT INFORMATION

Pain Specialty Consultants, P.A.
1200 Brooklyn Ave, # 140
San Antonio, Texas 78212
Phone (210) 527 1166 ● Fax (210) 527 1163 ● www.texaspainphysician.com

Patient's Name_____Date of Birth_____

Male ( ) Female ( ) Social Sec #_____ Phone #: Home_____
Work Phone_____

Full Mailing Address:_____

Primary Insured's Name_____Primary Insured's Date of birth_____

Primary Insured's Social Sec #_____Primary Insured's Employer_____

Primary Insured's Employer's Address_____
In case of emergency contact Name_____Phone #_____
Emergency contact address_____

Treating Physician (Primary Care)_____Phone #_____

Referring Physician_____Phone#_____UPIN_____

Lawsuit Pending ( ) yes ( ) no Attorney's Name _____Phone_____
Insurance Information:
Workers Comp( ) Private( ) PPO( ) HMO( ) Medicare A ( ) B ( ) Medicaid ( )

Carrier 1:_____

Carrier2:_____

*Workers Comp Claim#*_____
*Adjuster's Name*_____ *Phone #*_____

*Compensable Body Part*_____*Date of Injury*_____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and /or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim and understand that I am financially responsible for all charges incurred. As a courtesy my insurance will be billed but any charge not paid by my insurance on each visit will be my responsibility. I understand that unpaid charges may be sent to a collection agency. I have also reviewed the Notice of Privacy Practices of Pain Specialty Consultants dated effective 4-14-03, which explains how my health information will be used and disclosed. I authorize that my records may be released to my treating physician, referring physician or physicians or entities involved in my care. I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I also hereby consent to the use and disclosure of my health information for purposes of treatment, payment and other health care operations as set forth in the Notice of Privacy Practices. I will make the office aware of any insurance change prior to each visit or else be responsible for the charges.

Signature:_____