

Office Use

F/C : INS MC MD SP WC AA PI Z#

Included : Insurance Card Copy Employer Claim Form Referral

PATIENT INFORMATION

Thank you for choosing CHICAGO PAIN CENTER. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : _____ Patient's Soc. Sec. # : _____
 First Name : _____ M.I. : _____ Last Name : _____
 Date of Birth : _____ Male Female Are you pregnant? Yes No
 Mailing Address : _____
 Zip Code : _____ City : _____ State : _____
 Cell Phone : (_____) _____ Work Phone : (_____) _____
 Employer : _____ Occupation : _____

INSURANCE PATIENTS

Please complete the following section and present your Insurance Cards.

PRIMARY INSURANCE		SECONDARY INSURANCE	
Relation to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Complete the following Insured information if <i>RELATION</i> is other than <i>SELF</i> .			
Insured's Name:			
Insured's Birthdate:			
Insured's Social:			
Male or Female:			
Employer:			
Complete the following Insured information if it differs from the Patient's.			
Insured's Address:			
City, State, Zip:			
Phone Number:	(_____) _____	(_____) _____	

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	ATTORNEY INFORMATION
Date of Injury:	
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : (_____) _____	Phone : (_____) _____
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees, and 1% per month interest on past due balances, or other expenses incurred by the provider in collecting my account. I hereby order accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature : _____ Date : _____