The PAIN RELIEF Center
Your pain stops here.

Patient Intake Sheet

NAME (last, first):____________________, ____________________ DOB:________________

Address:____________________________ City:________________ State:_____ Zip________

SS#:_____-____-_____ Marital Status:________________ Gender: ☐ Female ☐ Male

Phone – Home:___________________ Work: ___________________ Cell: ___________________

E-mail Address:____________________________@______________________________

Employer:__________________________ Occupation:________________ Yrs. Employed:________

Referring Physician:__________________________ Phone:_______________________________

Address:____

Primary Care Physician: _______________________ Phone:________________________________

Address:____

Therapist/Counselor:_________________________ Phone:________________________________

Address:____

Emergency Contact

Name of person not living with you:___________________________ Relationship:________________

Address:_____________________________________ City:____________ State:___ Zip:______

Home / Cell Phone:_______________________________ Work Phone:_______________________

Insurance Information (all blanks must be filled in) Please provide insurance cards on day of visit.

☐ SELF-PAY ☐ INSURANCE

Primary INS Name: __________________________ Policy Holder:___________________________

ID#:________________________________ Group#:________________________________

SS# of Policy Holder: _____-____-_____ DOB of Policy Holder:_________________________

Employer of Policy Holder:________________________ Relationship to Patient:______________

Secondary INS Name: _________________________ Policy Holder:__________________________

ID#:________________________________ Group#:________________________________

SS# of Policy Holder: _____-____-_____ DOB of Policy Holder:_________________________

Employer of Policy Holder:________________________ Relationship to Patient:______________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

____________________________________ ____________________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE