Pacific Pain Specialists

www.pacificpainspecialists.com

PATIENT INTAKE FORM

Patient Name____

Date of Birth_______________________ Social Security # ____________________

Street Address_________________________________ Apt #______________

City/State:__________________________________ Zip ______________

Home Phone:______________Cell Phone:__________________ Ok to leave a Msg.phone Y/N

Emergency Contact_______________________ Phone:______________________

Referring Physician Name:_____________________ Phone:______________________

Primary Care Physician Name:___________________ Phone:____________________

Primary Location of Pain____________________ Onset Date/ Date of Injury______________

Is Injury work related? Y or N.   L&I claim #/Claim Mngr Name/Ph # ______________________

Is Injury due to auto accident? Y / N.   Claim Adj.Name/ Ph#___________________________

Ins. Name/Policy#____

Current Medications	Dosage	Times Per Day Taken

Previous Pain Treatments:(Injections,Physical Therapy,Chiropractor,Massage,etc)

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Allergies to medications ____

Past Medical History____

Past Surgical History____

Social History (Smoking,Alcohol,Single,Married,How many children) _______________________

Authorization & Assignment of Benefits for Insurance:

I hereby authorize payment of surgical / medical benefits directly to **Pacific Pain Specialists.**

Signature:_________________________________ **Date:**__________________

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PATIENT COMMUNICATION FORM

We are in the process of implementing a new appointment reminder and patient communication system for our practice. Please help us make sure we have the most current information for your account.

By providing your contact information below, you are granting permission to be contacted via those communication channels. Your information will not be abused and will only be used to contact you regarding your care. Example: communications include appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

Name____Home Ph#__________________________

Address____

Cell Ph#__________________________________Email_______________________________________

Please list any other minors of family members for which this same contact information applies.

____ ____

____ ____

____ ____

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone my limited protected health information, and to leave a message on my voicemail system or answering machine.

Signature____Date______________________