Date Info Taken: **ADVANCED PAIN CENTERS, S.C.** Provider:

NAME (LAST, FIRST, MIDDLE)	MALE/FEMALE	HOME PHONE	WORK PHONE

DATE OF BIRTH	AGE	SS#	DRIVER'S LICENSE #

ADDRESS	CITY	STATE	ZIP CODE

NAME OF PATIENT EMPLOYER	OCCUPATION	EMPLOYER TELEPHONE #

PATIENT EMPLOYER NAME, ADDRESS	CITY	STATE	ZIP CODE

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Active Military ☐ Retired ☐ Student-☐ Full ☐ Part Time

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Student EMAIL:

13. ARE YOU EMPLOYED? ☐ YES ☐ NO
14. IF YES, DO YOU RECEIVE HEALTH CARE BENEFITS FROM EMPLOYERS PLAN? ☐ YES ☐ NO
15. DOES THIS PLAN PAY YOU BEFORE MEDICARE? ☐ YES ☐ NO
16. IS YOUR CONDITION A RESULT OF AN ACCIDENT OR PERSONAL INJURY? ☐ YES ☐ NO
17. IS YOUR CONDITION COVERED UNDER A WORKMEN'S COMP CLAIM ? ☐ YES ☐ NO

DATE OF ACCIDENT/INJURY
16. ______________
17. ______________

IF YOUR CONDITION IS A RESULT OF A WORKERS COMP/ACCIDENT/PERSONAL INJURY PLEASE PROVIDE:

CLAIM ADJUSTER NAME	CLAIM #	TELEPHONE #

NATURE OF INJURY

ARE YOU INVOLVED IN A PAIN RELATED LEGAL CASE? ☐ YES ☐ NO IF YES,

NAME OF ATTORNEY	TELEPHONE #

ATTORNEY ADDRESS	CITY	STATE	ZIP CODE

PRIMARY INSURANCE INFORMATION ☐ GROUP/ MEDICAL ☐ WORKERS COMP ☐ AUTO

INSURANCE COMPANY NAME	TELEPHONE#	EFFECTIVE DATE

INSURANCE ADDRESS	CITY	STATE	ZIP CODE

OWNER OF INS POLICY (LAST, FIRST, MIDDLE)	SS#	D O B	INS ID #	GROUP #

SUBSCRIBER'S EMPLOYER	EMPLOYER PHONE	RELATIONSHIP

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

SECONDARY INSURANCE INFORMATION ☐ GROUP/ MEDICAL ☐ WORKERS COMP ☐ AUTO

INSURANCE COMPANY NAME	TELEPHONE#	EFFECTIVE DATE

INSURANCE ADDRESS	CITY	STATE	ZIP CODE

OWNER OF INS POLICY (LAST, FIRST, MIDDLE)	SS#	D O B	INS ID #	GROUP #

SUBSCRIBER'S EMPLOYER	EMPLOYER PHONE	RELATIONSHIP

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

ADVANCED PAIN CENTERS, S.C.

PERSON TO CONTACT IN AN EMERGENCY	EMERGENCY CONTACT PHONE #	RELATIONSHIP	
EMERGENCY CONTACT ADDRESS	CITY	STATE	ZIP CODE
REFERRING PHYSICIAN NAME		REFERRING PHYSICIAN PHONE	
ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE PHYSICIAN NAME		PRIMARY CARE PHYSICIAN PHONE	
ADDRESS	CITY	STATE	ZIP CODE

I hereby authorize Advanced Pain Centers, SC to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the Physician any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility**. IF ANY OF THE ABOVE INFORMATION IS INACCURATE OR INCOMPLETE AND THIS CAUSES MY CLAIMS TO BE UNPROCESSABLE OR DENIED, I UNDERSTAND THAT THE UNPAID BALANCES ARE MY RESPONSIBILITY.**

SIGNED________________________________ **DATE**____________________

SCHEDULING INFORMATION

DATE OF APPOINTMENT	TIME	OFFICE LOCATION	TYPE OF APPOINTMENT
	☐ AM ☐ PM	☐ HOFFMAN ESTATES ☐ WESTMONT	
PROCEDURE SCHEDULED		TIME	PROCEDURE LOCATION
		☐ AM ☐ PM	☐ HF ☐ PC ☐ AB ☐ HH ☐ HP ☐ ES ☐ OTHER____________
REASON FOR REFERRAL		PLEASE BRING	
		☐ MRI FILMS & REPORT ☐ CT SCAN FILMS & REPORT ☐ X-RAY FILMS ☐ MYELOGRAM FILMS & REPORT	

☐ **VISIT HAS BEEN PRE-CERTIFIED** ☐ **PROCEDURE HAS BEEN PRE-CERTIFIED** ☐ **REFERRAL OBTAINED**

SIGNATURE OF PRE-CERT: ________________________ **DATE:** ________________

☐ **NEW PATIENT PACKET SENT** ☐ **REFERRING PHYSICIAN INFO RECEIVED**

☐ **SELF PAY FEE $** __________ **# OF INSTALLMENTS** _____ **DUE DATES** ________________

GUARANTEE OF PAYMENT ☐ **ALREADY OBTAINED** ☐ **MUST BE OBTAINED**

SPECIAL COMMENTS: