Patient Information

Patient Name ______________________ Soc. Sec # _____-____-_____

Address ______________________ Home Phone ____________

City ______________________ State ________ Zip ____________

Date of Birth ________ Age _____ ☐ Single ☐ Married Email ____________

Preferred Language ________ Gender _____ Race _______ Ethnicity __ Hispanic __ Non-Hispanic

Employer ____________ Work Phone ____________ Cell Phone ____________

Referred by ____________ Emergency Contact ____________ Tel: ____________

Insured Information

Insured Name ______________________ Soc. Sec # _____-____-_____

Address ______________________ Home Phone ____________

City ____________ State ________ Zip ____________

Birth date ____________ Relationship ____________

Employer ____________ Work Phone ____________

Primary Insurance

Insurance Co. ______________________ Co-Pay ____________

Address ______________________ Phone ____________

City ______________________ State ________ Zip ____________

Policy # ______________________ Group # ____________

Work Related ☐ Yes ☐ No

Adjuster Name ____________ Date of Injury ____________

Secondary

Insurance Co. ______________________ Co-Pay ____________

Address ______________________ Phone ____________

City ______________________ State ________ Zip ____________

Policy # ______________________ Group # ____________

Authorization

Insurance Assignment and Medical Record Release

I, the undersigned do hereby authorize my insurance carrier(s) to pay directly to Nexus Pain Care the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay and/or deductible amounts. I, the undersigned, agree to pay all attorneys fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue such matters. I further agree to pay interest in the amount of 1.5% per month on any balance over 60 days. I, the undersigned, do hereby also give my permission to Nexus Pain Care to furnish my insurance carrier(s) any and all information pertaining to my medical records.

Signature: ______________________ Date: ____________