Phone: 314-729-0707 **Advanced Pain Control, Ltd.** Fax: 314-729-0718
12345 West Bend Drive, Suite 302 - St. Louis, Missouri, 63128

PLEASE PRINT **Today's Date: _____**

PATIENT'S NAME _____ SEX: M / F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE_____ MARITAL STATUS _____

HOME PHONE (____)_____ CELL (____)_____ EMAIL ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE _____

REFERRING DOCTOR _____ PRIMARY CARE DOCTOR _____

PATIENT EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS_____PHONE _____

PHARMACY _____PHONE_____ZIP CODE_____

PRIMARY INSURANCE INFO

INSURANCE: _____

INSURED:_____

POLICY # : _____

GROUP NAME: _____

RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE INFO

INSURANCE: _____

INSURED:_____

POLICY # : _____

GROUP NAME: _____

RELATIONSHIP TO INSURED: _____

WORKER'S COMPENSATION CLAIM ONLY

DATE OF INJURY _____ LAST DAY WORKED _____ CLAIM # _____

EMPLOYER AT TIME OF INJURY :_____

EMPLOYER ADDRESS AND PHONE : _____

ADJUSTER NAME AND PHONE : _____

WORK COMP INSURANCE / ADDRESS:_____

IF AUTOMOBILE ACCIDENT / OTHER INJURY (please provide the following information)

DATE OF INJURY _____ CLAIM # _____

INSURANCE CO. NAME _____ INSURANCE PHONE # _____

ADJUSTER NAME _____ ADJUSTER PHONE # _____

ATTORNEY NAME _____ ATTORNEY PHONE # _____

I hereby authorize my insurance company to pay all benefits directly to Advanced Pain Control, Ltd. I understand that execution of this assignment in no way relieves me of my financial responsibility, and any unpaid claims resulting in collection procedures may have fees assessed with them.
Also, I authorize Advanced Pain Control, Ltd., to release medical information pertaining to the patient's treatment to my insurance company and /or attorney, and /or Workmen's Compensation carrier as needed to process claims. I wish to authorize the following person (relationship) _____ to discuss information regarding my condition and medical information.

DATE: _____ SIGNATURE: _____