THE PAIN CLINIC, INC.

PATIENT REGISTRATION FORM

NAME			TELOFONO
DIRECCION	APT. #		TELEFONO DE TRABAJO
CIUDAD-ESTADO-CODIGO POSTAL			CELL #
EMERGENCY CONTACT	TELOFONO	SS #	CORREO ELECTRONICO
○ MALE ○ FEMALE	○S ○M ○D ○W	FECHADE NACIMIENTO	
EMPLEADOR		OCUPACION	
MEDICO PRIM		TELOFONO	
REFERIDO POR: ○ YELLOW PAGES ○ T.V ○ ATTORNEY ○ FRIEND/OTHER: WHOM:__________________		**REASON FOR VISIT:** ○CHIROPRACTIC ○ ACUPUNCTURE ○ MASSAGE THERAPY (CHECK ALL THAT APPLY)	

INSURANCE INFORMATION / METHOD OF PAYMENT

○CASH ○CHECK ○CREDIT CARD	○GENERAL HEALTH INSURANCE	○WORKERS' COMPENSATION INSURANCE	○AUTO INSURANCE

PLEASE INDICATE BY CHECKING YES OR NO IF YOU HAVE HEALTH BENEFITS (INSURANCE) AVAILABLE THRU THE H.E.R.E.I.U./CULINARY FUND
○ YES ○NO (WHICH INCLUDES LOCAL 226-CULINARY,LOCAL 369-MUSICIANS, LOCAL 165-BARTENDERS, LOCAL 720-STAGE HANDS)

INSURANCE COMPANY		CLAIM REPRESENTATIVE
POLICY #	GROUP #	CLAIM #
ADDRESS		
CITY-STATE-ZIP	PHONE #	
NAME OF INSURED	SS #	○SELF ○OTHER
AUTO MED –PAY INSURANCE COMPANY	POLICY #	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THE PAIN CLINIC, INC. TO RELEASE TO MY INSURANCE COMPANY AND ITS REPRESENTATIVES ANY INFORMATION NECESSARY TO OBTAIN PAYMENT OF MY BENEFITS. I ALSO AUTHORIZE AND REQUEST THAT MY INSURANCE COMPANY PAY DIRECTLY TO THE PHYSICIAN THE AMOUNT DUE FOR SERVICES RENDERED. I FURTHER AGREE THAT I WILL BE RESPONSIBLE FOR ALL NON-COVERED SERVICES, CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCES. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL CHARGES FOR MY TREATMENT. I CERTIFY THAT THE ABOVE INFORMATION TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

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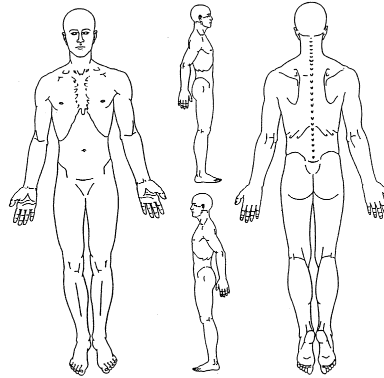
PATIENT OR GUARDIAN SIGNATURE DATE

THE PAIN CLINIC, INC.

HEALTH HISTORY

PLEASE INDICATE REGION OF COMPLAINT

O HEADACHE PAIN
O NECK PAIN
O UPPER/MID BACK PAIN
O LOW BACK PAIN
O SHOULDER-ELBOW-WRIST-HAND PAIN
O HIP-KNEE-ANKLE-FOOT PAIN
O OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS…

KEY
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O

MEDICAL HISTORY

	YES	NO	
▪ ARTHRITIC CONDITION	O	O	▪ LIST MEDICATIONS
▪ CANCER	O	O	-
▪ DIABETES	O	O	-
▪ HEART PROBLEMS	O	O	-
▪ HIGH BLOOD PRESSURE	O	O	▪ ALLERGIC TO MEDICATIONS
▪ VASCULAR CONDITION	O	O	-
▪ LUNG PROBLEMS	O	O	-
▪ USUAL CHILDHOOD DISEASES	O	O	▪ ALLERGIES
▪ UNUSUAL CHILDHOOD DISEASES	O	O	-
▪ CURRENTLY PREGNANT	O	O	-
▪ EXERCISE REGULARLY	O	O	▪ HEIGHT
▪ SMOKER	O	O	▪ WEIGHT
▪ ALCOHOL	O	O	▪ LIST SURGERIES / HOSPITALIZATIONS
▪ ALLERGIES	O	O	-
▪ BIRTH CONTROL MEDICATIONS	O	O	-
▪ OTHER			

SPECIFIC INJURY? O YES O NO	DATE OF INJURY
PREVIOUS TREATMENT? O YES O NO	TREATMENT TYPE
DOCTOR NAME	PHONE #

NATURE OF INJURY		
	O AUTO	COMPLETE SECTIONS 1 & 3 ONLY
	O WORK RELATED	COMPLETE SECTIONS 2 & 3 ONLY
	O HOME / OTHER	COMPLETE SECTION 3 ONLY

SECTION #1 – PERSONAL INJURY

DATE	TIME OAM OPM		LOCATION OF ACCIDENT
O AUTO V AUTO	O AUTO V TRUCK	O MOTORCYCLE	O AUTO V BUS

THE PAIN CLINIC, INC.

O AUTO V PEDESTRIAN	O SLIP & FALL	O OTHER	
PLEASE DESCRIBE INJURY			
O DRIVER OR O PASSENGER	O FRONT SEAT OR O BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	O YES O NO
BODY PARTS STRUCK	O YES O NO	IF YES, PLEASE LIST	
EMERGENCY TREATMENT?	O YES O NO	IF YES, WHERE?	
WORK –RELATED?	O YES O NO	IF YES, ANY WORK LOSS?	O YES O NO
LOSS OF CONSCIOUSNESS?	O YES O NO	WERE YOU BLEEDING?	O YES O NO
X –RAY TAKEN?	O YES O NO	IF YES, LIST AREAS	

SECTION #2 –WORKERS' COMPENSATION INJURY / EMPLOYER INFORMATION

COMPANY NAME			
ADDRESS			
CITY-STATE-ZIP			
TYPE OF BUSINESS			
OCCUPATION			
DATE OF INJURY	TIME OF INJURY	OAM / OPM	DATE LAST WORKED
DESCRIBE INJURY			
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]			