NEW PATIENT INTAKE FORM

COMPREHENSIVE PAIN & NEUROLOGY CENTER PLLC
RELIEVE PAIN AND RECLAIM LIFE

We rely on accuracy and completeness of this form to provide you with the best care possible. Please take your time and completely fill out each section. Thank you for your cooperation.

PATIENT INFORMATION

Name: _____ **Social Security Number:** _____

Date of Birth: _____**Age:** _____ **Gender:** ❑Male ❑Female

Street Address:_____ **City** _____ **State** _____ **Zip:**_____

Physical Address same as Mailing? ❑Yes ❑No **If not, list Mailing Address:** _____

Email: _____

Preferred Daytime Contact Phone: _____ **OK to leave message:** ❑Yes ❑No

Home Phone: _____ **OK to leave message:** ❑Yes ❑No

Driver's License #/State: _____ **Marital Status**: ❑Married ❑Single ❑Divorced ❑Widowed

Employment Status: ❑Full Time ❑Part Time ❑Not Employed ❑Self-Employed ❑Retired ❑Active Military

Name & Address of Employer: _____

Race: ❑American Indian or Alaskan Native ❑Asian or Pacific Islander ❑Black ❑White ❑Hispanic ❑Refuse to Report

Ethnicity: ❑Hispanic ❑Non-Hispanic ❑Refuse to Report Primary Language: ❑English ❑Spanish ❑Other

Emergency Contact Name: _____ **Address:** _____

Phone: _____ **Relationship:** _____ **OK to share HIPAA info with contact?** ❑Yes ❑No

REFERRAL SOURCE

Were you referred to our clinic by another medical provider? If so, whom? _____

If not, how did you hear about us? ❑TV ❑Radio ❑Insurance Company ❑Family ❑Friend ❑PCP

❑Billboard ❑Newspaper ❑tnpainexperts.com ❑Facebook ❑Online Search ❑Other: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone Number:** _____ **Fax Number:** _____

Street Address:_____ **City** _____ **State** _____ **Zip:**_____

PRIMARY INSURANCE PLAN

Payer: _____ **Plan:** _____

Policy/I.D. Number: _____ **Group Number:** _____

Yearly deductible: $_____ **Amount met: $**_____ **CPNC is** ❑ in network or ❑ out of network

PCP Referral required: ❑Yes ❑No **Prior Authorization required for procedures:** ❑Yes ❑No

Complete this box if you are not the policy holder for your primary insurance:

Insurance Policy Holder: ❑Self ❑Spouse ❑Child ❑Other

Policy Holder Name: _____ Policy Holder Gender: ❑Female ❑Male

Policy Holder's Date of Birth: _____ Policy Holder's Social Security No.: _____

SECONDARY INSURANCE PLAN (IF ANY)

Payer: _____ **Plan:** _____

Policy/I.D. Number: _____ **Group Number:** _____

Yearly deductible: $_____ **Amount met: $**_____ **CPNC is** ❑ in network or ❑ out of network

PCP Referral required: ❑Yes ❑No **Prior Authorization required for procedures:** ❑Yes ❑No

Complete this box if you are not the policy holder for your secondary insurance:

Insurance Policy Holder: ❑Self ❑Spouse ❑Child ❑Other

Policy Holder Name: _____ Policy Holder Gender: ❑Female ❑Male

Policy Holder's Date of Birth: _____ Policy Holder's Social Security No.: _____

WORKERS' COMPENSATION CLAIM INFORMATION

Complete this section only if your visit today is related to a Workers' Compensation claim.

Workers' Comp Company: _____ **Agent Name:** _____

Phone Number: _____ **Fax Number:** _____

Claim Number: _____ **Date of Initial Injury:** _____

AUTOMOBILE ACCIDENT CLAIM INFORMATION

Complete this section only if your visit today is related to an automobile accident.

Name of Responsible Party: _____ **Insurance Company:** _____

Policy No.: _____ **Agent Name:** _____

Phone Number: _____ **Fax Number:** _____

Claim Number: _____ **Date of Initial Injury:** _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTIFICATION

For a HIPAA notification, may we use your:

Daytime Contact Phone: ❑Yes ☑No Home Phone: ❑Yes ❑ No Physical Address: ❑Yes ❑No

Mailing Address: ❑Yes ❑No Email Address: ❑Yes ❑ No ❑ Other_____

How we may use your protected health information is set forth in our Notice of Privacy Policies and Practices available on our website at www.tnpainexperts.com or by asking for a copy from our Staff.

PATIENT'S SIGNATURE

All information provided above is true and correct. I understand that I am responsible for the entire cost of my treatment regardless of insurance coverage or payments. I hereby authorize the release of any medical information to process any insurance claims. I further understand that if it ever becomes necessary for this account to be turned over for collections, I am responsible for any collection and/or attorney fees. I authorize the release of any information needed to process my insurance claims. I authorize payment of insurance benefits directly to the physician otherwise payable to me. I hereby authorize and acknowledge that any scanned signature is considered an original signature.

_____ _____

Patient's Signature Today's Date