

# Patient Information Sheet

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_  
MARITAL STATUS:     Single     Married     Widowed     Divorced     Separated

**Street Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **ext.** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**EMPLOYMENT:**  
Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
**Spouse/Guardian Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

**Medication Allergies:** \_\_\_\_\_

**Referring or Family Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**INSURANCE:**

Commercial Ins     Self Pay     Auto Accident     Worker's Compensation     Medicaid/Medicare  
We will need copies of all your insurance cards. **PLEASE PROVIDE CARD TO BE COPIED.**

<b>Primary Insurance Company:</b> _____	
<b>ID Number:</b> _____	<b>Group Name:</b> _____
<b>Subscriber's Name:</b> _____	<b>Date of Birth:</b> _____
<b>Employer:</b> _____	
<b>Secondary Insurance Company:</b> _____	
<b>ID Number:</b> _____	<b>Group Name:</b> _____
<b>Subscriber's Name:</b> _____	<b>Date of Birth:</b> _____
<b>Employer:</b> _____	

<b><u>Worker's Compensation:</u></b>	<b>YES</b>	<b>NO</b>	circle one please
<b>Employer at Time of Accident:</b> _____			
<b>Date of Injury:</b> _____		<b>Claim#:</b> _____	
<b>Physician of Record:</b> _____		<b>Phone:</b> _____	
<b>Case Worker:</b> _____		<b>MCO:</b> _____	

<b><u>Motor Vehicle Accident:</u></b>	<b>YES</b>	<b>NO</b>	circle one please
<b>Date of Accident:</b> _____		<b>Claim#:</b> _____	
<b>Insurance Agent:</b> _____		<b>Phone:</b> _____	
<b>Billing Address:</b> _____			
<b>Attorney:</b> _____		<b>Phone:</b> _____	

How did you hear about our practice: \_\_\_\_\_

**Insurance Authorization & Assignment:** I hereby authorize Garden State Pain Control Center, PA. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_