

Address & Insurance Form

I. PATIENT:

Last Name	First	Middle Initial	Marital Status M _____ S _____ D _____ W _____
Date of Birth ____/____/____	Sex: F _____ M _____	S.S.#	
Address			Primary Phone # H / W / C
City	State	Zip	Secondary Phone # H / W / C
Race:	Language:	Alternate Phone # H / W / C	
Ethnicity: Hispanic or Latino / Not Hispanic or Latino			Pharmacy Name & #

II. GUARANTOR OF ACCOUNT (if different than above):

Last	First	Middle	Marital Status M _____ S _____ D _____ W _____
Date of Birth ____/____/____	Sex: F _____ M _____	S.S.#	
Address			Primary Phone # H / W / C
City	State	Zip	Secondary Phone # H / W / C
Relationship to Patient:			Alternate Phone # H / W / C

III. PATIENT PRIMARY INSURANCE: (present insurance card)

Insurance Company	Effective Date	Policy Holder Name
Policy # (or S.S.#)	Group #	
Address		Adjuster name & phone #
Check if Applicable: Worker's Compensation <input type="checkbox"/> Automobile Insurance <input type="checkbox"/> Date of Injury ____/____/____		

IV. PATIENT SECONDARY INSURANCE: (present insurance card)

Insurance Company	Effective Date	Policy Holder Name
Policy # (or S.S.#)	Group #	
Address		Adjuster name & phone #

V. NOTIFY IN CASE OF EMERGENCY:

Last	First	Phone #
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Assignment of Benefits Clause: I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services. I authorize direct payment of medical benefits to Twin Cities Pain Clinic for services rendered. I also authorize release of any information concerning my past medical care to my insurance companies, referring physician, or legal guardian.

Date: ____/____/____

Patient Signature	Guarantor Signature
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