PREMIER
SPINE AND PAIN CLINICS

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PATIENT INFORMATION

Patient Last:_____**First Name:** _____ **Middle**____ **DOB**:____ /____ /_____
Best Phone #:_____ Address_____
City_____**State**_____**Zip**_____
Open Workers Comp: Yes / No **Open Motor Vehicle Accident:** Yes / No **Date of Injury**:_____
Insurance Company_____ **Claim/ID#/Group**_____
Adjuster Name _____ **Phone#**_____

Chief Complaint/Diagnosis_____

PLEASE FAX COPIES OF IMAGING REPORTS (MRI, CT, X-RAY, ETC.) & OFFICE NOTES
PLEASE INDICATE THE PROCEDURE SIDE/SITE OR INDICATE EVALUATE AND TREAT

- ☐ Epidural Steroid Injection
- ☐ Selective Nerve Root Block
- ☐ Facet Joint Injection
- ☐ Medial Branch Block/Rhizotomy
- ☐ Sacroiliac Joint Diagnostic/Injection
- ☐ Percutaneous Discectomy
- ☐ Discography
- ☐ Trigger Point Injections
- ☐ Botox for Migraine/Cervical Dystonia
- ☐ Medical Cannabis Program
- ☐ Platelet Rich Plasma Therapy
- ☐ Peripheral Nerve Block
- ☐ Celiac Plexus Block
- ☐ Stellate Ganglion Block
- ☐ Spinal Cord Stimulator Trial/Implant
- ☐ Intrathecal Drug Pump Trial/Implant
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Joint (Shoulder,Elbow, Hip,Knee,Ankle,Foot)
- ☐ Consult for treatment
- ☐ Prolotherapy
- ☐ Other: _____

Specific Level desired(if applicable)_____ **at proceduralist's discretion**

REFERRING PROVIDER INFORMATION

Provider Name:_____ **Provider Clinic:** _____
Contact Person_____ **Phone**_____**Date** _____