HOUSTON PAIN SPECIALISTS

New Patient Intake Information

Patient Information

Name: _____ Today's Date_____

Date of Birth: _____ Age: _____ Social Security#: _____ ❑Male ❑Female

Preferred Phone: _____ ❑Home ❑Cell ❑Work

Secondary Phone: _____ ❑Home ❑Cell ❑Work

Home Address: _____

City/State/Zip: _____

Email: _____

Physical address same as mailing address? ❑Yes ❑No - please list mailing address:

_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Other

Race: ❑American Indian or Alaskan Native ❑Asian or Pacific Islander ❑Black or African American

❑Native Hawaiian or Other Pacific Islander ❑White ❑Hispanic ❑Non-Hispanic ❑Refuse to Report

Primary Language: ❑English ❑Spanish ❑Other: _____

Primary Insurance Plan

Insurance Name (ex: Medicare/ BCBS/ Aetna/ UHC/ Cigna/ Humana): _____

Plan: _____ Policy/ID #: _____ Group #: _____

*Complete this if you are **NOT** the policy holder for your primary insurance*

Policy Holder: ❑Spouse ❑Child ❑Other: _____

Policy Holder Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ ❑Male ❑Female

Secondary Insurance Plan (if any)

Insurance Name (ex: BCBS/ Aetna/ UHC/ Cigna/ Humana): _____

Plan: _____ Policy/ID #: _____ Group #: _____

*Complete this if you are **NOT** the policy holder for your primary insurance*

Policy Holder: ❑Spouse ❑Child ❑Other: _____

Policy Holder Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ ❑Male ❑Female

Referral Information

HOUSTON PAIN SPECIALISTS

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you find us? ❑Physician ❑Insurance ❑Family ❑Friend ❑Website ❑Other: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Street Address: _____ City/State/Zip: _____

Emergency Contact/Authorized HIPAA Contact Information

Emergency Contact Name: _____

Phone: _____ Relationship to Patient: _____

Worker's Compensation, Motor Vehicle or Injury Claim Information

Is your pain the result of a Worker's Compensation Injury? ❑Yes ❑No

Workers Comp Company: _____ Claim #: _____

Agent Name: _____ State of Injury: _____ Date of Injury: _____

Phone: _____ Fax: _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ❑Yes ❑No If yes, you will be asked to complete a separate form

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Houston Pain Specialists, PLLC (hereafter referred to as the "Practice") provide pain management care, anesthesia, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize the Practice to obtain and share my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Printed Name of Patient or Representative | Signature of Patient or Representative

_____ _____

Relationship to Patient | Date