Valley Pain Specialists, P.C.
Valley Surgical Center, Inc

Please fill out all information that applies, if it does not apply, please put N/A

Name		Home Phone#
Address		Cell Phone #
		Date of birth:
SS#	Gender: □ Male □ Female	Race:
Emergency Contact or Spouse		Phone:
Patient's Employer		Work Phone:

Referring Physician:	Phone & Address:
PCP/Family Physician:	Phone & Address:
Pharmacy:	Phone & Address:
Prescription Plan Name:	ID # and phone:

Primary Insurance Personal Coverage	**Secondary Insurance Personal Coverage**
Company Name	Company Name
Policy #/ID / Group#	Policy #/ID / Group#
Name of subscriber	Name of Subscriber
Subscriber SS# Subscriber DOB	Subscriber SS# Subscriber DOB

Fill out this block if your medical expenses will be covered by Worker's Compensation or Auto Insurance	
Insurance Company	Claim/Policy #
Phone #	Address:
Date of Injury:	Employer name/address:
Area of Injury:	Adjuster:

I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered. I hereby consent to treatment for myself. The release of medical information to any insurance carrier and direct payment to Valley Pain Specialists, P.C. and Valley Surgical Center, Inc for treatment or examination rendered is authorized.

Please Sign ____

Signature of Patient or Guardian Date

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Pain Specialists, P.C. and Valley Surgical Center, Inc, for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Please Sign ____

Signature of Patient or Guardian Date