In an effort to comply with governmental regulations regarding Meaningful Use our forms have been modified to capture additional data such as race, ethnicity, email address and contact information 03/13/2012

Georgia Pain Management, P.C.

Date: __________________

PATIENT DEMOGRAPHICS

(Please Print)

PATIENT INFORMATION

Social Security Number ______________________ Referring Doctor ____

Race: (Select One)
__ American Indian or Alaska Native __Asian __African American
__Hispanic __Native Hawaiian or Other Pacific Islander __White
__Other

Ethnicity: (Select One)
___Hispanic or Latino
___Not Hispanic or Latino

Preferred Language:
__English __Spanish
__Russian __Indian
__Other

Patients Name ____ Date of Birth ____________Gender: M F
Last First Middle

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Separated

Address ____
Street Address City State ZIP Code

Home Phone _______________________________
May we leave a voicemail message? **Yes** **No**
Preferred contact phone number **Home** **Cell** **Work**

Mobile Phone __________________________________
May we leave a voicemail message? **Yes** **No**

Employer _______________________________________

Work Phone __________________________________
May we leave a voicemail message? **Yes** **No**

Email address: _______________________________________ May we email medical information? **Yes** **No**

Emergency Contact: ____ Phone: ______________________

INSURANCE INFORMATION Please give your insurance card to the receptionist

PRIMARY INSURANCE

Name of Insurance Company ________________________________ Insurance Phone __________________________

Policy Number ____ Group Number ____________________________

Name of Insured ____ Insured Date of Birth ______________________

SECONDARY INSURANCE

Name of Insurance Company ________________________________ Insurance Phone __________________________

Policy Number ____ Group Number ____________________________

Name of Insured ____ Insured Date of Birth ______________________

I authorize **GEORGIA PAIN MANAGEMENT, P.C./SAMSON PAIN CENTER, P.C**. to release to my Insurance company(ies) and to other Physicians or facilities involved in my care any information required in the course of my examination or treatment. I also authorize the Center to provide details of my medical history to my insurance company in order to obtain reimbursement for medical benefits.

SIGNATURE: ____ **DATE:** ____________________

I authorize **GEORGIA PAIN MANAGEMENT, P.C/SAMSON PAIN CENTER, P.C.** to discuss my appointments, medical evaluation, treatment and results with the following people.

Authorized person 1. ____Date of Birth ______________________

2. ____Date of Birth ______________________

I hereby assign to **GEORGIA PAIN MANAGEMENT, P.C/SAMSON PAIN CENTER, P.C**. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amounts not covered by insurance.

_________ I received a copy of the "Notice of Privacy Practices" for my records.
(Initials)

SIGNATURE: ____ **DATE:** ____________________