

PATIENT INFORMATION

PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Marital status:	
Ethnicity:	Race:	Language:	Patient's Birth Date:	Age:	Sex: <input type="radio"/> M <input type="radio"/> F
Address:					
Patient's Social Security:		Patient's Phone:		Patient's Email:	
Referring Physician/Location:		Family Physician:			
PRIMARY INSURANCE INFORMATION					
Please give your insurance card to the receptionist.					
A Guarantor is the person who has insured the patient on their plan and/or accepts financial responsibility for the patient.					
Guarantor's Last name:		First:	Middle:	Relationship:	
Primary Insurance Company:	Primary Insurance no.:		Guarantor's Birth Date:		
SECONDARY INSURANCE INFORMATION					
Please give your insurance card to the receptionist.					
A Guarantor is the person who has insured the patient on their plan and/or accepts financial responsibility for the patient.					
Guarantor's Last name:		First:	Middle:	Relationship:	
Secondary Insurance Company:	Secondary Insurance no.:		Guarantor's Birth date:		
ALTERNATIVE COMMUNICATION INFORMATION					
I give permission to the following person(s) to receive information regarding my medical care with Pain Specialists of Iowa:					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone:	Work phone:	
I give permission to leave detailed messages on the voicemail regarding (check boxes below): <input type="checkbox"/> Appointments <input type="checkbox"/> Diagnosis <input type="checkbox"/> Diagnostics <input type="checkbox"/> Plan of Care					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone:	Work phone:	
This form of communication will be used as the standard until revoked in writing by the patient or his/her guardian.					
Patient's/Guardian's Signature:			Date:		