



**ADVANCED  
PAIN MANAGEMENT**

**Welcome To Our Office**

**PATIENT INFORMATION**

Patient Name	Social Security No.	
Street	Date of Birth	Gender M__F__
City & State	Zip Code	Occupation
Telephone -Home	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed	
Telephone - Work	Employer Name & Address	
Telephone - Other	Emergency Contact:	Phone:
Marital Status: Single ___ Married ___ Significant Other ___ Widowed ___	Primary Care Physician:	
<b>How were you referred to us? Please Circle One: Newspaper / Friend/ Doctor/ Website / Radio</b>	Referring Physician:	
	What Pharmacy do you use?	
<b>Are you currently in one of the following: ___ Nursing Home ___ Assisted Living ___ Rehab Facility If so is this a temporary stay? YES Or NO</b>		
<b>FINANCIAL RESPONSIBILITY (please give insurance cards and photo ID to front desk with this form)</b>		
<b>Primary Insurance</b>		<b>Secondary Insurance</b>
Primary Insurance Name	Secondary Insurance Name	
Name of Insured	Name of Insured	
Relationship to Insured:	Relationship to Insured:	
Insured Social Security No	Insured Social Security No	
Insured Date of Birth	Insured Date of Birth	
Insurance Policy ID #	Insurance Policy ID #	
Group #	Group #	
Claims address:	Claims address:	
Telephone:	Telephone:	

**All co-payments and/or deductible payments are due at the time of your visit today.**

**If you do not have insurance, payment in full is expected at the time of your visit today.**

***Payment for Professional Services Rendered***

I understand that many procedures performed by Advanced Pain Management (APM) are highly specialized and demand extensive education and training. I also understand that the fees for services provided by APM may exceed the amount paid by my insurance company. I agree to pay APM the contractually agreed upon co-insurance, deductible, or eligible charge as determined by the contract APM currently has with my insurance carrier. In those situations wherein APM **is not a contracting provider** with my insurance company, I understand that I must pay that portion, if any, of my bill that is not covered by my health insurance. I understand that by signing this agreement as patient or as agent, I obligate myself to pay my account in full.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_