MAGIC VALLEY
PAIN SPECIALISTS

Patient Information

Please take a few moments to complete this form in its entirety. All information will be considered confidential and will be released only as allowed through HIPPA regulations, and as considered necessary for treatment, payment, or other health care operations.

First Name_____ **Last Name**_____ **MI** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Gender _____ **Date of Birth** _____ **Age** _____ **SSN** _____

Race _____ ☐ **Decline Primary Language** _____

Employer _____ **Work Phone** _____

Employer Address _____ **City** _____ **State** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Accident Related? ☐ **Yes** ☐ **No Type:** ☐ **Auto** ☐ **Work** ☐ **Other Date of Injury** _____

If work-related: Adjuster/Case Manager Name _____ **Phone** _____

Referring Physician _____ **Primary Care Physician** _____

How did you learn about our clinic? _____

Responsible Party/Guarantor Information (If parent or legal guardian/conservator of patient)

Name of person responsible for this account _____ **Relationship to patient** _____

Daytime Phone _____ **Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Employer Phone** _____

Insurance Information

Primary Insurance:	**Secondary Insurance:**
Insured Name:	**Insured Name:**
Policy ID: **Group #:**	**Policy ID:** **Group #:**
Relationship to patient:	**Relationship to patient:**
Date of Birth: **SSN:**	**Date of Birth:** **SSN:**
Insured's Employer:	**Insured's Employer:**
Phone	**Phone**

Disability Forms: As a pain specialist practice WE DO NOT COMPLETE DISABILITY FORMS or work release forms. These forms should be completed by your primary care doctor. Please do not request, nor expect our office to perform this service for you.

Consent to Treat: I undersigned, authorize medical treatment for myself or my minor child, _____, as deemed necessary and provided by Magic Valley Pain Specialist physicians and medical staff.

Patient Printed Name: _____

Patient or Parent/Guardian Signature: _____ **Date:** _____