RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS

Patient Information Record

(Please Use **BLACK** or **BLUE** Ink Only)

PATIENT DEMOGRAPHICS

Date: _____ Referred by: _____

Name: _____
First M.I. Last

Date of Birth: _____ SSN: _____

Employment Status: ☐ Employed ☐ Retired ☐ Disability Student- ☐ Full time ☐ Part time

Employer: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D

Ethnicity: ☐ Hispanic or Latino Race: _____

☐ Not Hispanic or Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Communication Needs: _____

Residence Address: _____

_____

_____

Mailing Address: _____

☐ *Check here if the same* _____

_____

Home Phone: _____ Okay to receive phone call reminders?

Work Phone: _____ ☐ Yes ☐ No

Cell Phone: _____

Email Address: _____

EMERGENCY CONTACT *(other than someone living with you)*

Name: _____ Relationship: _____

Home Phone: _____ Alternative Phone: _____

Address City/State/Zip: _____

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RESPONSIBLE PARTY ☐ *Check here if same as above*

Name: _____
First M.I. Last

Date of Birth: _____ SSN: _____

Mailing Address: _____

Home Phone: _____ Relationship: _____

Employer: _____ Work Phone: _____

Responsible Party's Spouse's Name *(if applicable)*: _____

INSURANCE COVERAGE *Is your illness/injury due to an Auto/Work Accident?* ☐ Yes ☐ No

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: _____ Guarantor: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: Guarantor:

Tertiary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: _____ Guarantor: _____

PREFERRED PHARMACIES

Name: _____ Telephone: _____

Name: _____ Telephone: _____