



(PLEASE COMPLETE ENTIRE FORM)

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ARE YOU PARTICIPATING IN WORKMAN'S COMPENSATION? YES \_\_\_ NO \_\_\_

IF SO, NAME AND ADDRESS OF EMPLOYER: \_\_\_\_\_

\_\_\_\_\_ DATE OF ACCIDENT \_\_\_\_\_

CASE WORKER: \_\_\_\_\_ PHONE: \_\_\_\_\_

IS YOUR INSURANCE UNDER SPOUSE'S/PARENT'S? YES \_\_\_ NO \_\_\_

IF YES, SPOUSE'S / PARENT'S SSN \_\_\_\_\_

IF YES, SPOUSE'S / PARENT'S DATE OF BIRTH \_\_\_\_\_

WHO REFERRED YOU TO OUR CLINIC? \_\_\_\_\_

(PLEASE INCLUDE DOCTOR'S FIRST AND LAST NAME IF REFERRED BY PHYSICIAN)

PRIMARY EMERGENCY CONTACT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

SECONDARY EMERGENCY CONTACT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**I understand that my insurance company/Medicare requires having my signature on file. I request payment of insurance/Medicare benefits be made on my behalf to Nebraska Pain Consultants. I understand I am responsible for payment in full on my account. PATIENTS ARE RESPONSIBLE FOR ANY PRE-CERTIFICATION NEEDED FOR ALL INSURANCE . PATIENT IS RESPONSIBLE FOR ACCOUNT BALANCES.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date