Apex
PAIN SPECIALISTS

PATIENT DEMOGRAPHIC INFORMATION

(Print Legibly) **Please fill in all blanks.**

Patient Name (Last, First, Middle)			
Street Address:	City:	State:	Zip:
Home Phone: ( ) Cell/Message Phone: ( ) Email (optional)	Patient's Sex: ☐ Male ☐ Female	Patient's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Other	
Birth Date:	Social Security #:	Patient's Employment Status: ☐ Employed FT ☐ Retired ☐ Student ☐ Disabled	
Patient's Employer:		Employer's Phone Number: ( )	
Employer's Street Address:	City:	State:	Zip:
Referred By:	Do you have? Living Will ☐ Yes ☐ No Medical Power of Attorney ☐ Yes ☐ No		

Primary Care Physician: _____

Pharmacy Name: _____ Major Cross-Streets:_____

Emergency Contact: _____

Telephone: _____

Relationship To Patient:_____

RESPONSIBLE PARTY INFORMATION / SECONDARY ADDRESS:			
Name (Last, First, Middle)			
Street Address:	City:	State:	Zip:
Social Security Number:	Phone Number: ( )		
Employer's Name:		Employer's Phone Number: ( )	
Employer's Street Address:	City:	State:	Zip:

PRIMARY INSURANCE:		Policy Holder's Name: ID #: Group:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child	Policyholder's Birth Date:	Policyholder's Sex: ☐ Male ☐ Female
Policyholder's Employer:		

SECONDARY INSURANCE:		Policy Holder's Name: ID #: Group:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child	Policyholder's Birth Date:	Policyholder's Sex: ☐ Male ☐ Female
Policyholder's Employer:		

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Apex Pain Specialists, PC. I understand that I am financially responsible for any non-covered services. I also authorize Apex Pain Specialists, PC to release any information required to process this claim. I certify that the information provided above is true and correct to the best of my knowledge. I will notify Apex Pain Specialists, PC of any changes to this information.

Signed: _____

Date: _____