PAIN AND HEALTH MANAGEMENT CENTER

For Office Use Only : Site ________
Dr. ____________ Initial ________

Date ____________________
Last Name ____________________ First Name ____________________ Middle Initial ________

Home Address ____

City/State/Zip ____________________ Home Phone (   ) ____________

Occupation ____________ Employer ____________ Work Phone (   ) ____________

Social Security Number ____________ Birthdate ____________ Sex M ☐ F ☐

Marital Status ____________ Referred by ____________________
Nearest Relative Not Living With You ____________ Relationship ____________ Phone (   ) ____________

IS THIS A WORK RELATED INJURY? YES ☐ NO ☐
If YES, please complete the fields denoted ◆.

IS THIS A PERSONAL INJURY CASE? YES ☐ NO ☐
If YES, please complete the fields denoted ○.

◆○Date of Injury/Accident ____________ ◆○ Claim Number/ Reference Number ____________ ◆TWCC Number ____________

◆Employer at time of Injury ____________________ ○Auto Accident? YES ☐ NO ☐ Enter State ____________

◆Employers' Address ____________________ ◆City/State/Zip ____________________

◆Employers' Phone (   ) ____________ ◆ Adjustor Name ____________ ◆Treating Physician ____________

◆○Insurance Carrier ____________ ◆○Address ____________________

◆○City/State/Zip ____________________ ◆○Insurance Phone (   ) ____________

DO YOU HAVE MEDICARE/MEDICAID? YES ☐ NO ☐ If YES, please complete the following information.
Medicare Number as it appears on your card ____________ Medicaid Number as it appears on your card ____________
Is this your primary insurance? YES ☐ NO ☐ If you have secondary insurance, please list it below..

Primary Insurance ____________________ Phone (   ) ____________

Address ____________________ City/State/Zip ____________________
Insured's Name ____________ Insured's Social Security Number ____________ Insured's Birthdate ____________
Insured's Employer ____________________
Employer Address ____________________ City/State/Zip ____________________

Group Number ____________ Policy Number ____________ Effective Date ____________

Secondary Insurance ____________________ Phone (   ) ____________

Address ____________________ City/State/Zip ____________________
Insured's Name ____________ Insured's Social Security Number ____________ Insured's Birthdate ____________
Insured's Employer ____________________
Employer Address ____________________ City/State/Zip ____________________

Group Number ____________ Policy Number ____________ Effective Date ____________

—CONFIDENTIAL—