Advanced Orthopedic
PAIN MANAGEMENT & WELLNESS CENTER

PATIENT INFORMATION

Thank you for taking the time to fill out this confidential patient information form.

Name:_____ Sex: Male☐ Female☐

Date of Birth: ___/___/_____ Age:_____ SS#:_____

Address: _____

City, State, Zip: _____

Phone: _____ Marital Status:_____

Who is referring you to our practice? _____

Who is your Primary Care Physician?_____

Emergency Contact: _____ Relationship:_____
Phone:_____ Other Phone:_____

Guarantor: Same as Patient: ☐Yes ☐No. If not, Please fill out Guarantor Information.
Name:_____ Date of Birth: ___/___/_____
Address:_____
SS#:_____ Employer:_____
Phone:_____ Other Phone:_____

I hereby authorize and consent to examination and treatment as deemed necessary by physicians and allied medical practitioners of Advanced Orthopedic Pain Management and Wellness Center Inc.

I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Advanced Orthopedic Pain Management and Wellness Center Inc. in the collection of amounts due including, but not limited to, reasonable attorney's fees. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advanced Orthopedic Pain Management and Wellness Center Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

I, the undersigned, understand that payment for all care received is my responsibility. I also understand that a 24-hour cancellation notice is necessary to avoid charges. A $35.00 fee is charged for cancellations given with less than 24 hours notice and for missed appointments.

Today's Date: ___/___/_____ Patient (Guardian) Signature:_____

Patient (Guardian) Name (Please Print):_____