

## **Patient Information Sheet**

**Please answer all questions completely. This information is necessary for us to properly identify you & handle all your insurance matters.**

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
**Physical** Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Mailing** Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Maiden Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Sex: F \_\_\_ M \_\_\_ Marital Status: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Spouse/significant other Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
In case of emergency please notify:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Insurance Information**

Please complete ALL of the insurance information below, even if you have given us a copy of your insurance card. All co-payments are to be paid PRIOR to seeing the physician.

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Relationship to patient: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_  
Policy Holder's Employer: \_\_\_\_\_ Retired: Yes \_\_\_ No \_\_\_  
Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Plan: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Relationship to patient: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_  
Policy Holder's Employer: \_\_\_\_\_ Retired: Yes \_\_\_ No \_\_\_  
Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Plan: \_\_\_\_\_

### **PLEASE READ CAREFULLY BEFORE SIGNING**

I hereby authorize payment of medical benefits from my insurance companies to be paid directly to Integrative Pain Services, P.A. or Mark S. White, DO. I also authorize the release of medical information necessary to secure payment from my insurance carrier or other third party. I understand that I am fully responsible for all charges accumulated while under the care of the physician, regardless of insurance, and that full payment is due at the time of service unless I have made PRIOR arrangements.

\_\_\_\_\_  
Patient or Legal Guardian's Signature

\_\_\_\_\_  
Date