Specialized Medicine

BOLTZ

PAIN AND WELLNESS CENTER

Welcome to Boltz Pain Center, LLC

Please fill out completely:

Patient Information

Patient Last Name_____ First Name_____ Middle Initial _____

Address_____ City_____

State_____ Zip Code_____ E-mail_____

Sex: ☐ Male ☐ Female Age: _____ Date of Birth:_____ Social Security # _____-_____-_____

Height _____ Weight _____

☐ Married ☐ Widowed ☐ Single ☐ Seperated ☐ Divorced ☐ Minor

Occupation _____ Employer _____

Employer'saddress_____Employer'sPhone(_____)_____

Spouse's Name _____ Date of Birth _____

SocialSecurity#_____/_____/_____Spouse'sEmployer_____Phone:(____)_____

Please list any persons that you will allow access of your medical records.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Insurance Information

Insurance Company _____Policy Number _____Group Number _____

Subscriber's Full Name _____Date of Birth _____-_____-_____ Relationship to Patient _____

Is patient covered by additional insurance? Yes No

Secondary Insurance Co. _____Policy Number _____ Group Number _____

Please read the following carefully:

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Patricia Boltz all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance . I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information and to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of patient, parent, guardian or representative

_____ _____ _____

Please print name Date Relationship to patient

Workman's Compensation

Is this a workman's comp claim? ☐ Yes ☐ No

Date of Injury _____/_____/_____

Adjustor's Name_____

Telephone Number _____

Phone Numbers

Home Phone Number _____

Cell Phone Number_____

Best time and place to reach you _____

Emergency Contact Information:

Name _____

Relationship _____

Home number_____

Cell Number _____