PAIN MANAGEMENT INSTITUTE

Zaki Anwar, M.D.
Interventional Pain
Management Specialist

Corporate Office
Pain Management Institute
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(815) 464-7251 – Fax

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Ingalls Family Care Center
19550 Governors Highway
Suite 1400
Flossmoor, IL 60422

(708) 922-1902 – Phone
(708) 922-1825 – Fax

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Social Security #: _____ Marital Status: (circle one) M S D W Sex: M F

Employer: _____ Work #: _____

Referring Physician: _____ Office #: _____

Primary Care Physician: _____ Office #: _____

INSURANCE INFORMATION

Policy Holder: _____ Relationship: _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ Zip Code: _____

Primary Insurance: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Group #: _____ ID #: _____ Effective Date: _____

Secondary Insurance: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Group #: _____ ID #: _____ Effective Date: _____

(Circle one)
Workers Compensation **Auto** **Personal Injury** Date of Injury: _____ Claim #: _____

Insurance Carrier: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Adjuster**:** _____ Phone #: _____

Attorney name**:** _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Emergency Contact_____ Relationship:_____

Home #: _____ Cell #: _____ Work #: _____

Who would you like report send to?

_____ Phone:_____

_____ Phone:_____

AUTHORIZATION TO RELEASE INFORMATION: I verify that all the information contained on these information sheets is true and correct, to the best of my knowledge.

I hereby authorized the physician of Pain Management Institute to release any information acquired in the course of my treatment to process insurance claims and to or from other physicians of medical facilities that may be pertinent and necessary to my care and treatment.

_____ _____

Signature of Patient or Authorized Person Date

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby authorize payment of all benefits directly to the physician of Pain Management Institute for all surgical and or medical services proceeded to me. I realize that I am responsible to forward any such monies paid to me and to pay for all co-payments, deductibles and any non-covered services. I have received and read the financial policy. I understand this policy and will adhere to the policy.

_____ _____

Signature of Patient or Authorized Person Date