SECKIN
PAIN MANAGEMENT

Date: _____

Patient name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ __M __H

Secondary Phone: _____ __M __H

Email: _____ Permission to email __Y __N

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Marital Status: S M W D

Employer (if applicable): _____

Emergency Contact Information:

Name: _____ Relationship: _____ Ph: _____

May we contact this person in case of an emergency? Initial here: _____

Pharmacy: _____ City: _____ State: _____

Seckin Pain Management has permission to obtain my Rx History (Initial here): _____

Is your condition referred to as a work related injury? ____ Motor vehicle accident? _____

Primary Insurance Holder: _____ DOB: _____

If you have Medicare, is it your primary insurance? _____

Signature below is acknowledgement that you have received the notice re: our HIPAA/Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

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Date: _____

Patient Name: _____ DOB: _____

Height: _____ Weight: _____

Current Medications: (Please specify dosage information)

_____ _____

_____ _____

_____ _____

_____ _____

Medical History:

_____ _____

_____ _____

_____ _____

Surgical History:

_____ _____

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

_____ _____

Signature below confirms that the above information is true and correct to the best of my knowledge:

Print Name: _____ Signature: _____ Date: _____

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Please circle all symptoms that apply:

- Fever
- Weight Loss
- Fatigue
- Blurring of vision
- Eye pain
- Trouble hearing/ringing in ears
- Dizziness
- Ear pain
- Chest pain (angina)
- Irregular heartbeats (palpitations)
- Hypertension (high blood pressure)
- Fainting
- Trouble breathing
- Chronic cough
- Indigestion
- Heartburn
- Abdominal pain
- Nausea/vomiting
- Diarrhea
- Constipation
- Incontinence
- Pain during urination
- Blood in urine
- Muscle pain
- Muscle cramps
- Neck pain
- Weakness
- Back pain
- Joint pain
- Joint stiffness
- Joint swelling
- Numbness
- Hair loss
- Headache
- Weakness
- Tremors
- Trouble concentrating
- Memory loss
- Hallucination
- Suicidal idealation
- Feeling depressed
- Abnormal bleeding
- Anemia
- Skin rash
- Excessive thirst

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ASSIGNMENT OF BENEFITS

I hereby authorize Seckin Pain Management to apply for Medicare/Medigap and other health insurance benefits (if applicable, no fault and worker's compensation) on my behalf. I request payment of Blue Cross/Blue Shield and other insurance carriers be made directly to the above provider. I certify that the information I have reported regarding my insurance carrier(s) is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, including all other information needed to determine the benefits payable for related service(s). I hereby authorize payments of Medigap benefits to be made on my behalf to above named providers. I release any holder of Medicare information about me to my insurance carrier(s) necessary to determine benefits payable for related services.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Seckin Pain Management and its associates to provide treatment and;/or examination and release any information pertinent to my case, in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney (if applicable). I hereby authorize Seckin Pain Management to obtain any medical information from my referring physician including, but not limited to, clinical history and office notes.

Signature: _____ Date: _____

FINANCIAL POLICY

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to our insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not covered by your insurance is your responsibility and will be due and payable upon receipt of a billing statement. Should your insurance carrier deny your claim you give us the right to appeal your claim on your behalf. If the correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of the charges incurred. If you do not have medical insurance, financial arrangements must be made prior to services rendered. Otherwise, full payment will be expected at the time of services. If account should become delinquent and is forwarded to our collection agency and/or attorney, the collection agency or attorney fee will be added to the balance due.

Signature: _____ Date: _____