SOUTHWEST PAIN MANAGEMENT
Relief begins here.

Dr. Robert Groysman, MD

Bob DeLillo, CRNA, NSPM-C, ARNP, CNPM, AFAAPM

PATIENT INFORMATION FORM

PRINT PLEASE

TWO PAGE FORM COMPLETE AND SIGN BACK OF THIS FORM

REGISTERED BY: _____

PATIENT NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	DRIVERS LICENSE #	SOCIAL SECURITY NUMBER

RESIDENCE ADDRESS: NUMBER STREET	CITY	STATE	ZIP CODE	Gender

MAILING ADDRESS: PO NUMBER IF APPLICABLE	CITY	STATE	ZIP CODE	

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

EMERGENCY CONTACT NOT LIVING WITH YOU	RELATIONSHIP	PHONE NUMBER	SECONDARY PHONE NUMBER

PATIENTS EMPLOYMENT

YOUR CURRENT EMPLOYER NAME: (BUSINESS NAME)	DIRECT WORK PHONE NUMBER

EMPLOYER PHYSICAL ADDRESS:	DIRECT EMAIL ADDRESS

	CURRENT POSITION (TITLE)	DEPARTMENT	

SPOUSE, DOMESTIC PARTNER OR GUARANTORS EMPLOYMENT

LAST	FIRST	MIDDLE	DATE OF BIRTH	DRIVERS LICENSE #	SOCIAL SECURITY NUMBER

CURRENT EMPLOYER NAME: (BUSINESS NAME)	DIRECT WORK PHONE NUMBER

EMPLOYER PHYSICAL ADDRESS:	DIRECT EMAIL ADDRESS

	CURRENT POSITION (TITLE)	DEPARTMENT	

YOUR PERSONAL PHYSICIAN INFORMATION

REFERRING DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	REFERRING DOCTOR PHONE NUMBER

FAMILY DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	FAMILY DOCTOR PHONE NUMBER

HEALTH PLAN INFORMATION-

WC Patients Please list private insurance under secondary

PRIMARY INSURANCE COMPANY	INSURANCE PHONE NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER

SUBSCRIBERS NAME	RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY NUMBER

SECONDARY INSURANCE	INSURANCE PHONE NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER

SUBSCRIBERS NAME	RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY NUMBER

SIGN & COMPLETE THE INFORMATION ON THE BACK OF THIS FORM IN ITS ENTIRITY

WORKERS' COMPENSATION INFORMATION

TO COMPLY WITH CALIFORNIA WORKERS' COMPENSATION REGULATIONS PERTAINING TO WORK RELATED INURIES. MPMC MUST HAVE DETAILED INFORMATION TO ENSURE THAT YOUR MEDICAL CARE IS AUTHORIZED AND SUBMITTED PROMPTLY FOR CLAIMS PROCESSING IF YOUR MEDICAL CARE IS COVERED BY WORKERS' COMPENSATION INSURANCE. WORKERS' COMPENSATION PATIENTS ARE REQUIRED COMPLETE ALL OF THE INFORMATION IN THIS SECTION IN ITS ENTIRITY. IF YOU ARE NOT AWARE OR SURE

OF THIS REQUIRED INFORMATION PLEASE CONTACT THE EMPLOYER, WHERE YOU WORKED, WHEN YOU WERE INJURED. THAT EMPLOYER HAS AN OBLIGATION TO PROVIDE YOU WITH THIS NECESSARY CLAIMS MANAGEMENT INFORMATION.

IS YOUR MEDICAL CARE AT MPMC ATRIBUTED TO A WORK RELATED INJURY? ☐ **YES** ☐ **NO**

DATE OF INJURY MM/DD/YYYY	ADJUSTERS NAME	ADJUSTERS PHONE NUMBER	WORKERS' COMPENSATION CLAIM NUMBER

NAME OF WORKERS' COMPENSATION INSURANCE	ADDRESS OF W/C INSURANCE	CITY	STATE	ZIP CODE

NAME OF EMPLOYER AT TIME OF INJURY	LOCAL MAILING ADDRESS	CITY	STATE	ZIP CODE

DO YOU HAVE AN ATTORNEY REPRESENTING YOU? ☐ **YES** ☐ **NO**

WHAT IS YOUR WORKERS COMPENSATION APPEALS BOARD (WACB) NUMBER: _____

NAME OF ATTORNEY AND LAW FIRM	LAST	FIRST	PHONE NUMBER

ADDRESS OF ATTORNEY:	NUMBER & STREET	CITY	STATE	ZIP CODE

I _____ authorize my Southwest Pain Management (SPM) physician and any other physician or therapist who provides care or services to me as well as my attorney and pharmacy to exchange information relating to my medical condition(s)/services provided. If I am hospitalized during the course of my care with SPM. I authorize the hospital to release information to SPM regarding any treatment provided to me.

If my treatment is covered by an acceptable insurance, I hereby authorize my benefits to be paid directly to SPM. I understand that I am financially responsible for all deductibles, co-payments, products and services not covered by my insurance company

I authorize SPM to release, to my insurance company, contracted reviewing agency and/or state or governmental agency, any information necessary on the processing of my medical claim, including information relating to medical condition(s).

All information disclosed within these sessions meets applicable standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and will not be released without my written permission except as identified above and disclosure is required by law. I have been provided with a copy of this "Notice of Privacy Practice" and have been informed a copy of the complete notice is available for review in the Lobby at SPM. I may also request a copy of the notice.

Disclosure or PHI may be required by law in the following circumstances: when there is reasonable suspicion of child or elder abuse, when there is reasonable suspicion that the patient presents a danger of violence to others or themselves. Disclosure may also be required pursuant to a legal proceeding.

This authorization shall extend for the duration of my treatment at SPM unless otherwise specified in writing by me or my responsible representative(s).

_____ (Initial) I have received a copy of SPM rights and responsibilities.

Please place an X in the box that applies and sign authorization form.

☐ **Patient** ☐ **Parent** ☐ **Guardian of Minor** ☐ **Guardian or conservator of an incompetent patient**

☐ **Beneficiary or personal representative of deceased patient**

Date: _____ **Signature:** _____