Sunrise Institute

For Pain Management

6535 Rochester Road, Suite 102
Troy, MI 48085

New Patient Information Record

FULL LEGAL NAME

Last Name _____ First _____ Middle_____

Address _____ City _____ State _____ Zip _____

Home telephone ( ) _____ Date of Birth _____ Sex _____ Age _____

Race _____ Social Security # _____ Martial Status _____

Spouse's Name _____ Spouse's Date of Birth _____

PATIENT EMPLOYER INFORMATION

[ ] Currently employed [ ] Unemployed [ ] Retired [ ] Legally disabled

Company Name _____ Address _____

City _____ State _____ Zip _____ Work telephone ( ) _____

IF MARRIED, PLEASE LIST SPOUSE'S EMPLOYMENT INFORMATION

SS#_____ Employer _____

City _____ State _____ Zip _____ Telephone # ( ) _____

NEAREST RELATIVE NOT LIVING AT HOME

Name _____ Relationship _____ Telephone # ( ) _____

Address _____ City _____ State ____ Zip _____

PRIMARY CARDHOLDER INFORMATION (If different from patient)

Name _____ SS# _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home telephone # ( ) _____ Work # ( ) _____ Cardholder's employer _____

Cardholder's work address _____ City _____ State ___Zip _____

LOCATION & TYPE OF PAIN _____

_____

Referring Doctor _____ Telephone # ( ) _____

Doctor's address _____ Suite # _____

City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN

Name _____ Telephone # ( ) _____

Address _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company _____ Cardholder's Name _____

Policy # _____ Group # _____

SECONDARY INSURANCE COMPANY

Insurance Company _____ Cardholder's Name _____

Policy # _____ Group # _____

WORKER'S COMPENSATION INFORMATION

Date of Injury _____ Claim # _____ Ins. Carrier _____

Address _____ City _____ State ___ Zip _____

Telephone # ( ) _____ Adjuster _____

Employer at time of injury _____ Description of accident _____

Employer's address at time of injury _____

Treating MD _____ Address _____

City _____ State _____ Zip _____ Telephone # ( ) _____

Circle One

Y N INSURANCE AUTHORIZATION
I hereby authorize Enter Name Here to furnish information to my insurance carriers concerning my illness and treatment.

Y N ASSIGNMENT OF BENEFITS
I hereby assign to Sunrise Institute For Pain Management all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Y N TREATMENT AUTHORIZATION
I hereby authorize Sunrise Institute For Pain Management to render health care to me during my visit.

Y N PRIVACY NOTICE
I have received a Notice from Sunrise Institute For Pain Management that explains how my personal health information will be used

Signature _____ Date _____