DEMOGRAPHIC FORM

PREMIER
PAIN MANAGEMENT

33 Electric Ave, Suite 102, Fitchburg, MA 01420
Phone: (978) 343-PAIN Fax: (978) 343-7247
www.premierpainfitchburg.com

Patient Demographic Information

Patient Name: _____
Is this your legal name: □ Yes □ No If no, what is your legal name: _____

Date of Birth: _____ **Age:** _____ **Marital Status:** _____

Social Security Number: _____-_____-_____ **Gender:** ☐ Male ☐ Female

Street Address: _____

City, State, Zip Code: _____

Email Address: _____

Physical Address same as Mailing Address? □ Yes □ No If not, please list mailing address:

_____

Preferred Phone: (_____) - _____ - _____ □ Home □ Mobile □ Work

Secondary Phone: (_____) - _____ - _____ □ Home □ Mobile □ Work

Emergency Contact Name: _____

Phone Number: (_____) - _____ - _____ **Relationship:** _____

Primary Care Physician Name: _____
Phone Number: (_____) - _____ - _____

Referring Physician Name (if different): _____
Phone Number: (_____) - _____ - _____

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Primary Insurance Information

Payer/Insurance Company: _____ **Plan:** _____

Subscriber Name: _____ **Subscriber Birth Date:** _____

Patient Relationship to Subscriber: □ Self □Spouse □ Child □ Other _____

Policy/I.D. Number: _____ **Group Number:** _____

Telephone number on the back of your insurance card: (_____) - _____ - _____

What is your specialty co-pay? $_____

What is your in-network deductible? $_____

Employer: □ Hospital □ Health Plan □ Other_____

Employer Name: _____

Please indicate the type of Primary insurance you have:

□ Commercial □ Medicare □ Medicaid □ Affordable Care Act □ Other_____

Please indicate if you have any of the following:

□ Health Reimbursement Account (HRA) □ Flexible Spending Account (FSA)
□ Health Savings Account (HSA)

Is Medicare primary? □ Yes □ No

Complete this section only if you are NOT the policyholder of your primary insurance

Insurance Policy Holder: □ Self □Spouse □ Child □ Other _____

Policy Holder Name: _____ **Gender:** ☐ Male ☐ Female

Date of Birth: _____ **Social Security Number:** _____-_____-_____

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Secondary Insurance Information (if any)

Payer/Insurance Company: _____ **Plan:** _____

Subscriber Name: _____ **Subscriber Birth Date:** _____

Patient Relationship to Subscriber: □ Self □Spouse □ Child □ Other _____

Policy/I.D. Number: _____ **Group Number:** _____

Telephone number on the back of your insurance card: (_____) - _____ - _____

Complete this section only if you are NOT the policyholder of your secondary insurance

Insurance Policy Holder: □ Self □Spouse □ Child □ Other

Policy Holder Name: _____ **Gender:** ☐ Male ☐ Female

Date of Birth: _____ **Social Security Number:** _____-_____-_____

Workers Compensation Information

Complete this section only if your visit is related to a Workers Compensation claim

Workers Compensation Company: _____

Agent Name: _____ **State of Injury:** _____

Phone Number: (_____) - _____ - _____ **Fax Number:** (_____) - _____ - _____

Claim Number: _____ **Date of Injury**: _____

Adjustor's Name: _____
Adjuster's Telephone Number: (_____) - _____ - _____

Lawyer name and phone number (if you have one): _____
Body Areas the Claim Covers: _____

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Motor Vehicle Accident or Personal Injury

Complete this section only if your visit is related to a Motor Vehicle Accident or Personal Injury

Auto Insurance Company: _____
Auto Insurance Company Address: _____
City, State, Zip Code: _____

Adjustor's Name: _____
Adjuster's Telephone Number: (_____) - _____ - _____

Lawyer name and phone number (if you have one): _____

Claim Number:_____

Date of Injury:_____

Body Areas the Claim Covers: _____

Certification

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Premier Pain Management, PLLC or insurance company to release any information required to process my claims.

Signed: _____ **Date:** _____
(Patient, parent, guardian, patient representative)

Printed Name:
_____