

Dayton Pain Center, LLC. (DPC)

1 Elizabeth Pl Suite # 230, Dayton, OH 45408
(937) 222 2233 Fax (937) 222 9665

Patient Name: _____ SSN#: _____ - _____ - _____ DOB: _____ / _____ / 19 _____

Sex: M / F Address: _____ City: _____ OH Zip: _____

Home Tel #: (_____) _____ Work Tel #: (_____) _____ Cell Tel #: (_____) _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single / Married / Widowed Family Doctor: _____ Tel #: (_____) _____

Spouse's Name: _____ Spouse's SSN#: _____ / _____ / _____

Spouse's Employer: _____ Spouse's Employer Tel #: (_____) _____

Spouse's Employer address: _____ City: _____ State: _____ Zip: _____

Who may we thank for referring you to us: _____ Tel #: (_____) _____

Referring Physician Name: _____ Tel #: (_____) _____ Fax # _____

Ref Physician Address: _____ City: _____ OH Zip: _____

Reason for Referral: _____

In case of emergency who may we contact: _____ Tel #: (_____) _____

Is this visit due to injury: Yes / No Type of injury: Auto / Industrial

Nearest relative not living with you: _____ Tel #: (_____) _____

Nearest friend not living with you: _____ Tel #: (_____) _____

Landlord Name: _____ Tel #: (_____) _____

INSURANCE INFORMATION Financial Responsible party for this bill _____

Insurance Company Name: _____ Policy # _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ SS# _____ / _____ / _____ Group # _____

AUTHORIZATION: I hereby authorize DAYTON PAIN CENTER, LLC. to release any information concerning my illness and treatments and that of my dependents. I also authorize payment of medical benefits of DPC for services rendered. I understand and agree (regardless of my status) that I am ultimately responsible for all the charges for any professional services rendered. I have read all the information on this sheet and have completed all the answers. I CERTIFY this information is true and correct to the best of my knowledge. I will notify any changes in my status or the above information.

Responsible party Signature: _____ Date: _____ / _____ / _____