PRECISION
PAIN CENTER
INSURANCE • WORKERS' COMP • PERSONAL INJURY

Stuart Baird, MD
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PATIENT INFORMATION
Informacion del paciente

Patient's last name (*Apellido*): First (*Nombre*): Middle (*Segundo nombre*): ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Birth date (*Fecha de nacimeinto*):	Age (*Edad*):	Social Security Number (*Seguro Social*):

Marital status (circle one): Single (*Soltero/a*) Married (*Casado/a*) Divorced (*Divorciado/a*) Separated (*Separado/a*) Widowed (*Viudo/a*)	Sex: ☐ M ☐ F	Home phone (*Telefono*):

Street address (*Direccion*):	Cell phone (*Cellular*):

P.O. Box:	City (*Ciudad*):	State (*Estado*):	Zip Code (*Codigo postal*):

Occupation (*Ocupacion*):	Employer (*Empleo*):	Employer phone number (*Telefono del empleo*):

Referred to clinic by (*Referido por*):

IN CASE OF EMERGENCY
En caso de emergencia

Name (*Nombre*):	Relationship to patient (*Relacion al paciente*):	Telephone number (*Numero de telefono*):

INSURANCE INFORMATION
Informacion de su aseguranza

Insurance company (*Aseguranza*):	Subscriber's name (*Nombre del suscriptor*):	Subscriber's SSN (*Seguro social del suscriptor*):	Birth date (*Fecha de nacimiento*):

Policy number (*Poliza*):	Group number (*Numero de grupo*):	Patient's relationship to subscriber (*Relacion al paciente*): ☐ Self ☐ Spouse ☐ Child ☐ Other:

Occupation (*Occupacion*):	Employer (*Empleo*):	Employer phone number (*Telefono del empleo*):

Name of secondary insurance (*Segunda aseguranza*):	Subscriber's name (*Nombre del suscriptor*):	Subscriber's SSN (*Seguro social del suscriptor*):	Birth date (*Fecha de nacimiento*):

Policy number (*Poliza*):	Group number (*Numero de grupo*):

ATTORNEY INFORMATION

Informacion de su abogado

Attorney's name *(Nombre del abogado)*:	Phone number *(Numero de telefono)*:	Date of accident *(Fecha del accidente)*:

** Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below, not to do so.

I, **DO NOT** want my health insurance billed: Signature ___________________________________ Date ________

Please be advised that if you later decide to bill Health Insurance it will be billed from that time and date only.

PLEASE CHECK MARK HERE IF YOU ARE A: ☐ **SELF PAY/ CASH PAY**

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 Precision Pain Center or my insurance company to release any information required to process my claims.

____ ___________________________

Patient/Guardian signature *(Firma del paciente o guardian)* Date *(Fecha)*

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Patient Name: ______________________________**Date of Birth:** ________________ **Date:**____________

Date of injury (if applicable): ____________________How did it start?______________________________

Have you been treated for you present problem? ☐Yes ☐No When? _______ By whom? ____________

Indicated which of the following you have tried for you pain and if it helped:

__________Pain Clinic/Anesthesiologist __________Anti-inflammatory/Anti-Depressant
__________Trigger Point Injections __________Epidural Steroid Injection
__________Chiropractic Therapy __________Physical Therapy

How long are you able to sit/stand comfortably? __________ How far are you able to walk? ____________

Circle the words that describe your pains:

ACHING	SHARP	PENETRATING	THROBBING	GNAWING
SHOOTING	BURNING	UNBEARABLE	MISERABLE	NAGGING
NUMBNESS	STABBING	OCCASIONAL	TENDER	CONTINUOUS

Do you use tobacco (smoke/chew)? ☐Yes ☐No If yes, how much and for how many years? _________

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per day/week? ______________________

Do you or have you used recreational drugs? ☐Yes ☐No If yes, which ones? ____________________

What is your occupation? ____

What is your employment status now? ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Unable to work due to pain/injury.

Height: _______ Weight: ________ Have you experienced any sudden weight loss or gain? _____________

Are you or could you be **Pregnant/Nursing**? ___________________ Date of last period? _____________

Do you have any **ALLERGIES** (ex: medication, latex gloves, tape?) ☐Yes ☐No If yes, please list:

____
____

Prior Medical History (list ALL previous illness type and date):

____
____

Prior Surgical History (list previous surgeries, type and date):

____
____

List previous **Serious Injuries** (ex. Fractures with date):

____
____