# PATIENT INFORMATION

**Pain Treatment Associates, LLC**

*Your Pain Management Specialists •1410 Doctors Drive •West Plains, MO 65775 Phone: (417) 256-BACK*

**LEGAL NAME First**_____ **Middle** _____ **Last** _____ **DOB** ___/___/_____

**PHYSICAL Address, City & State *(NO P.O. Boxes)*:** _____ **Zip**: _____

**MAILING Address, City & State:** □Same _____ **Zip**: _____

□**Home Phone:** _____ □**Cell:** _____ □**Message:** _____

*Check box of preferred contact phone*

□**Email** (will not be sold, for patient portal access)**:** _____ **SSN#** _____-____-_____

**Marital Status:** □Single □Married □Divorced □Widowed □Legally Separated **Race\Ethnicity:** □White/Not Hispanic □American Indian or Alaska Native □Asian □Native Hawaiian or Other Pacific Islander □ Black or African American □Hispanic/Latino □Other_____ **Primary Language Spoken:** □English □Other_____ **Student:** □N/A □Full-time □Part-time

**Primary Care Physician** (family doctor):_____ Phone: _____ **City:** _____

**Pharmacy Name:** _____ Phone: _____ **City:** _____

**Employer Name & Contact Name:** _____ □Ok to contact me at work □Please do not call my work

**Employment:** □Employed □Unemployed □Retired □Disabled **Work Phone:**_____ **Address:**_____

**Is this visit a result of an accident?** □Work related □Auto □Other **Date of accident:** _____ **Claim#:**_____

**State accident occurred:** _____ **Case Worker:** _____ **Phone:** _____

**Attorney:** _____ **Address:** _____ **Phone:** _____

***If patient is under 18**** *Father's Name:* _____ *DOB:___/___/___ Phone:* _____

*Address: □ Same as above □Other* _____ ** Mother's Name:* _____
*DOB:_____/_____/_____Phone:*_____ *Address: □ Same as above □Other* _____

## Release of Protected Health Information

I authorize Pain Treatment Associates, LLC to release my protected health information regarding my care to people I list below. I have also been notified and offered a copy of the Notice of Privacy Practices.

**Emergency Contact Name:** _____ **Relationship**: _____

**Address:** _____ **Phone:** _____

Name_____ Relationship_____ Phone_____ Address_____

Name_____ Relationship_____ Phone_____ Address_____

Name_____ Relationship_____ Phone_____ Address_____

Name_____ Relationship_____ Phone_____ Address_____

□ *I have listed more individuals on the back of this form*

**Patient Signature**_____ **Date** _____/_____/_____