South Florida Surgical Specialists, LLC
Interventional Pain and Wellness Center

Patient:

_____

Last Name **First** **M.I**

Address: _____

_____

City **State** **Zip Code**

Home phone: _____ **SS#:** _____

Date of birth: _____ **Age:** _____

Patient's Employer: _____**Occupation:** _____

City of Employment: _____ **Phone #:** _____

Spouse's Name: _____ **Spouse's DOB:**_____

Spouse's Employer: _____ **Phone #:** _____

Nearest Relative: _____ **Phone #:** _____

Referred by: _____ **Primary Physician:** _____

Primary Insurance: _____ **ID#:** _____ **Group:** _____

Address:_____

******If you are NOT the primary policy cardholder, WE NEED the following information***** Primary Cardholder name:** _____ **DOB:** _____ **SSN:** _____

Secondary Insurance: _____ **ID#:** _____ **Group:** _____

***I give permission to the physicians of Interventional Pain and Wellness Center to administer medical treatment to me and authorize the release of all medical information necessary for my treatment.**
Sign: _____

***I authorize the release of my medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to go directly to South Florida Surgical Specialists, LLC. I authorize photocopies of this form to be valid as the original.**
Sign: _____**Date:** _____

***By signing below you are giving permission to be contacted via Internet by South Florida Surgical Specialists,**
Sign: _____**Email Address:** _____
Payment is expected when services are rendered