DAVID KLOTH, MD
CONNECTICUT PAIN CARE

Patient Information

Name: _____ Tel# (Home): _____

Work# :_____ Cell #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status S__ M __ W__ D__

Social Security #: _____ Occupation: _____

Employer: _____ Address: _____

Spouse's Name: _____ Spouse's Employer: _____

Address: _____ Phone#: _____

Emergency Contact (Other Than Spouse): _____

Telephone#: _____ Alt. #: _____

Name of Referring Physician: _____ Phone#: _____

Name of Family Physician (PCP): _____ Phone#: _____

Insurance/Billing Information

Please List Your First Insurance Company to be Billed (primary)

Name of Company: _____ ID#: _____

Group#: _____ Subscriber Name: _____ Effective Date: ____

Please List Your Second Insurance Company to be Billed (Secondary)

Name of Company: _____ ID#: _____

Group#: _____ Subscriber Name: _____ Effective Date: ____

Is Present Injury/Illness Work Related? Yes _____ No _____ Date of Injury: _____/____/____

Worker's Compensation Carrier: _____ Claim #: _____

Adjuster: _____ Phone#: _____

Is the Present Injury/Illness related to an Automobile Accident? Yes _____ No _____

Date of Injury: _____ Is this an Open Claim? _____

Name and Address of Attorney retained for above (or different) incidence if applicable:

Name: _____ Address: _____

Phone: _____

Please feel free to provide any additional information you feel is relevant to collecting on

charges accrued at Connecticut Pain Care: _____

_____

I Hereby Assign All Medical/Surgical Benefits to Which I am Entitled to Connecticut Pain Care for Services Performed By Them.

This Assignment Will Remain In Effect Until Revoked By Me in Writing. I Understand that I am Financially Responsible for all Charges Whether or not such Charges are Reimbursed by Insurance. I Hereby Authorize Said Assignee to Release All Information Necessary to Secure the Payment of Said Benefits. I Further Permit a Copy of the Authorization to be used in Place of the Original.

_____

Signature of Patient **Date**