

HEADACHE AND PAIN CENTER, AMC

APPOINTMENT DATE: _____ TIME: _____ PHARMACY NAME: _____ PH #: _____

PATIENT'S NAME _____ DATE _____

MAILING ADDRESS _____ AGE _____

STREET

CITY

STATE

ZIP

SEX _____ DATE OF BIRTH _____ SOCIAL SEC. # _____ (AREA CODE) PHONE _____

GUARANTOR'S NAME _____

PATIENT EMPLOYER: _____ (AREA CODE) BUSINESS PHONE: _____

SELF EMPLOYED: Y N (CIRCLE ONE)

BUS. _____ OCCUPATION _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIVE OR NEIGHBOR NOT LIVING WITH YOU: _____

PHONE: _____

NOTIFY IN CASE OF EMERGENCY - NAME _____ RELATIONSHIP _____

PHONE # _____ ADDRESS: _____

PERSONAL PHYSICIAN: _____

WAS THIS CONDITION DUE TO AN ACCIDENT? _____ YES _____ NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

DATE OF ACCIDENT _____

WORKMAN'S COMPENSATION _____ YES _____ NO IF YES, THRU _____

LIABILITY _____ YES _____ NO IF YES, ADJUSTER OR LAWYER _____

HEADACHE AND PAIN CENTER, AMC

HEADACHE FORM

PLEASE FILL OUT IF YOU HAVE HEADACHES.

1. _____ How frequently do you have headaches?
2. _____ Where are they located?
3. _____ What time of day do your headaches start?
4. _____ From the beginning of the headache, how long does it take to reach maximum intensity?
5. _____ How long do your headaches last?
6. _____ Do you notice any symptoms before the headache begins ("aura")?
7. _____ How would you characterize the headache pain? Is it burning, shooting, sharp, dull or pounding?
8. _____ Does anything help the headache?
9. _____ List of medications you are (if not yet listed) presently taking or have taken for your headaches: _____
10. _____ List other therapies for your headaches: _____
11. _____ Do you experience any of the symptoms below during your headache?
12. _____ Please name family members that have headaches.

(Please circle)

Nausea	Yes	No
Vomiting	Yes	No
Numbness	Yes	No
Tingling	Yes	No
Sensitivity to Light	Yes	No
Sensitivity to Noise	Yes	No
The Need to Walk or Move Around	Yes	No

**HEADACHE AND PAIN CENTER, AMC
ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE**

I hereby assign and authorize payment made directly to **Headache and Pain Center, A Medical Corporation** of the covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross/Blue Shield, Medicare, Medicaid, Medigap, and/or commercial insurance companies. Any payment for services provided made directly to me by my insurance company will be endorsed by me payable to Headache and Pain Center, AMC and forwarded to this office immediately. **I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance, and payments from insurance companies sent directly to me. I understand any payment made directly to me by my insurance company will be endorsed by me and forwarded to Headache & Pain Center, A Medical Corporation, for payment of services rendered. In consideration of the medical services furnished to me, I hereby agree to pay Headache and Pain Center, A Medical Corporation any balance due within ninety days. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney's fees incurred.**

This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including secondary and tie-in coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I have had an opportunity to discuss with the physician or his staff to my satisfaction the nature of the services provided. **I acknowledge that no guarantees have been made to me as to the results.** I am satisfied that I fully understand this assignment and its significance.

I agree to promptly notify your office of any change of address or changes in insurance coverage.

A copy of this assignment shall be considered as valid as the original.

X _____
Signature of Patient

X _____
Signature of Insured (if applicable)

Social Security # _____

Social Security # _____

Employer-Firm _____

Employer-Firm _____

Insurance
Company _____
(Primary)

Insurance
Company _____
(Secondary)

SIGN BELOW IF YOU HAVE A MEDIGAP (SECONDARY INSURANCE TO MEDICARE) INSURANCE POLICY
MEDICARE LIFETIME MEDIGAP ASSIGNMENT
(A secondary policy to Medicare)

I assign and authorize payment of Medigap benefits to Headache & Pain Center, A Medical Corporation for any services furnished to me by them. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____ Date _____

Medigap No. _____ Medigap Insurer _____

