Inland Northwest
ANESTHESIA AND PAIN

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Male ☐ Female ☐

Social Security #: _____ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

E-Mail Address: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Who referred you to us? _____

Is this a work related injury? Yes ☐ No ☐ Date of injury: _____

Preferred Pharmacy: _____

Please list individuals we are authorized to speak with regarding your care/account: (Include the last four digits of their social security number *or* their mother's maiden name for verification purposes. Thank you.)

Name: _____ Last Four Digits of SS# or Mother's Maiden Name: _____

Name: _____ Last Four Digits of SS# or Mother's Maiden Name: _____

Parent or Guardian (For Minors Only):

Name: _____ Date of Birth: _____ (Required)

Social Security #: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Insurance Information (Primary/Secondary) * Please Provide Insurance Card For Us To Copy * Thank you!

_____ **HIPPA** I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ **MEDICATION REFILL POLICY** If you receive a prescription medication from our office and need a refill, please request a refill from your preferred pharmacy. The pharmacy will contact our office regarding your refill request. It could take up to 48 hours to process your refill request so please plan accordingly.

To the best of my knowledge, all of the above information is true and true complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. **IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE RQUEST THAT CO-PAYS AND/OR OUT OF POCKET BALANCES BE PAID AT THE CONCLUSION OF EACH VISIT.** Thank you.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to Inland Northwest Anesthesia for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original. This assignment of benefits is authorized for Medicare and any/all other insurances that may be applicable at the time of service.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____