DAVID M. RATZMAN, M.D.

ANESTHESIA PAIN CONSULTANTS of INDIANA

Evaluation and Treatment of Acute
and Chronic Pain Disorders
Interventional Pain Management
Spinal Pain, Cancer Pain
Pain Fellowship Trained, Board Certified

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PATIENT DEMOGRAPHICS CONFIDENTIAL

Today's date________________

Name ____

Social Security Number ____________________Date of Birth__________

Marital Status______________ Spouse name ____________________

Home Address____

____

Home Phone ____________Work Phone __________Cell Phone____________

If the patient is a child, responsible party______________________________

Relation to patient ____________________SSN______________________

Address____

Home Phone____________________ Work Phone______________________

Can our office call you at home _____and/or work ________

Can we leave you a message at home ______ and/or work ________

Who can we release your health information to (i.e : spouse, parent, child) __________

____

Employer ______________________________Phone______________

Address____

Is this a work comp. issue? YES_____ NO_____ Date of injury______________

Claim/Account number____________________________________

Case Manager____

Case Manager Phone ____________________fax________________

Is there a legal case pending YES _____ NO _____ Date of Incident____________

Name of attorney____

Address____

Phone___________________________ Fax_____________________________

For emergency purposes, name of friend/relative we may contact regarding you.

Name ___________________________ Relation________________________

Address____

Home phone______________________ Work Phone______________________

THIS FORM MUST BE COMPLETED IN FULL

Primary Ins. Co. Name____

Policy Holder ____________________Relation to patient____________________

SSN__________________ Date of Birth ______________ Phone______________

Insured's Employer____

Secondary Ins. Co. Name____

Policy Holder ____________________Relation to patient____________________

SSN__________________ Date of Birth ______________ Phone______________

Insured's Employer____

Tertiary Ins. Co. Name____

Policy Holder ____________________Relation to patient____________________

SSN__________________ Date of Birth ______________ Phone______________

Insured's Employer____