Pain and Recovery Clinic
San Antonio, TX

6851 Citizens Parkway, Suite 225
San Antonio, TX 78229
Phone: 210-299-1444
Fax: 210-299-1446

General Patient Information - Please Print Clearly

Patient Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ State: _____

Zip: _____ Sex: Male ____ Female ____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Date of Birth: _____ (mm/dd/yyyy)

Drivers License # and State: _____ Email Address: _____

Preferred Contact (check one): Home Phone ____ Cell Phone ____ Work Phone ____ Email ____

Marital Status (check one): Single ____ Married ___ Divorced ____ Widow ____ Other____

Spouse Name: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Please Check: Asian ____ Black or African American ____ Hispanic ____ White ____

Other ____ (If Other, Please Describe) _____

Please Check: Major Medical ____ Cash Pay ____ Auto Accident ____ Workmen's Comp ___

Other ____ (If Other, Please Explain) _____

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Date of Injury or Accident: _____ Time of Injury or Accident: _____

First Date of Disability (If Worker's Comp): _____ (mm/dd/yyyy)

Injured Body Part(s): _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip: _____ Employer Contact: _____

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Referred by: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip: _____

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General Patient Information - Please Print Clearly

Insurance Company: _____

Address: _____ City: _____ State: _____

Zip: _____

Adjuster: _____ Phone: _____

Precert Company: _____ Fax: _____

Claim Number: _____ TWCC Number: _____

ID Number: _____ Group Number: _____

Group Name: _____

Insured Name: _____ SSN: _____

I hereby authorize payment and assign to Pain and Recovery Clinic of San Antonio and their doctors all insurance benefits for services rendered. I understand that I am financially responsible for all charges.

_____ _____
Signature of Patient, Guardian or Personal Representative **Date**

_____ _____
Please Print Name of Patient, Guardian or Personal Representative **Relationship to Patient**

For Office Use Only

Reviewed: Yes ____ No_____ Approved: Yes ____ No ____ Initials: _____ Date: _____ (mm/dd/yyyy)