PAIN WEST

URGENT CARE INTAKE R1.2026 Patient Number (Office Use):_____

How were you referred to our office? _____Today's Date_____

Patient Name (Last, First, Middle)_____

Birth date:_____Age:_____ Gender: Male / Female

Address:_____City:_____State:_____Zip:_____

Home #:_____Mobile #:_____Work #:_____

Email:_____SS #:_____ Driver's License #:_____

Best way to contact? Home # / Work # / Mobile # / Email / Text

Occupation:_____Employer:_____Address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Marital Status: M / S / D / W Name of Spouse / Partner:_____# of Children:_____

Race:_____Ethnicity:_____Preferred Language:_____

PAYMENT / INSURANCE

Self Pay / Medicare / Medicaid / General Insurance / Auto Accident / Work Comp

Primary Insurance:_____Policy #:_____

Secondary Insurance:_____Policy#:_____

Insured's Name (Last, First, Middle):_____

Birth Date:_____ Who carries this policy? Self / Spouse / Parent

Insured's Employer:_____Address:_____

City:_____State:_____Zip:_____Employer's Ph:_____

WHAT CAN WE HELP YOU WITH?

_____

_____

Is this related to an auto accident? Y / N If yes, what was the date of injury?_____

Is this related to a work injury? Y / N If yes, what was the date of injury?_____

Are you currently under medical care? Yes / No If Yes, what for?_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____

PAIN WEST

MEDICAL & SOCIAL HISTORY

Primary Care Provider? _____

Are you pregnant? *(females)*	Y / N	Do You Exercise Regularly?	Y / N
Do you regularly use alcohol?	Y / N	Do you regularly use tobacco?	Y / N
Do you use recreational drugs?	Y / N	Are you currently taking NSAIDs?	Y / N

Have you previously been diagnosed with any diseases / conditions? Y / N

If yes, please list_____

Previous surgeries / hospitalizations? _____

Previous accidents / injuries? _____

Current medications? _____

Family illnesses? _____

Known Allergies? _____

ACKNOWLEDGEMENTS & PERMISSION

- I acknowledge that I have read and understand Pain West's ***Consent to treat*** form and agree to its terms.
- I acknowledge that I have read and understand Pain West's ***Assignment of Benefits*** form and agree to its terms.
- I acknowledge that I have read and understand Pain West's ***Health Privacy Policy*** (HIPAA) form and agree to its terms.
- (*If applicable*) Being the legal guardian, I authorize Pain West to evaluate and treat our ***Minor Child*** for the presenting condition(s). (*child name*)_____
- I understand that I am responsible for all charges not covered by insurance.
- I acknowledge that I may be contacted by phone, email, or text for clinical, administrative, and billing purposes, and that patient statements and account notices may be sent electronically via email or text.
- I authorize ***Release of all Medical Records*** from this visit to: (please include: *name* / address / phone)_____

Patient's (or Guardian) Signature_____Date_____

Doctor's Signature_____Date_____