



**Please Print Clearly**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell/Other Phone ( ) \_\_\_\_\_ SS# \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone ( ) \_\_\_\_\_

---

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

ID Number \_\_\_\_\_ Policy/Group Number \_\_\_\_\_ Group Name \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_

ID Number \_\_\_\_\_ Policy/Group Number \_\_\_\_\_ Group Name \_\_\_\_\_

---

Referring Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

---

Release: I certify the above is complete and correct. Authorization is hereby given to Orange County Pain Center/C. Eddy Chan DO to release to my insurance company/health plan any information acquired during the course of my examination and treatment that is deemed necessary to adjudicate a claim. I authorize my insurance/health plan to pay benefits directly to Orange County Pain Center/C. Eddy Chan DO. I also understand I am financially responsible for any services or charges not covered by my insurance/health plan.

Signature of Patient or Legal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_