Comprehensive Pain Care, P.C.

Donald Taylor, M.D.
Wendy Gray, M.D.

Date: _____ Status: (circle one) Minor Single Married Widow(er) Divorced Separated

Patient Name: _____ SS# _____

Address: _____

Date of Birth: _____ ☐ Male ☐ Female Home Phone: _____

Employer name/address: _____

Work Phone: _____ Cell / pager _____

Spouse: _____ SS# _____ Birthdate _____

Employer name/address: _____

Family Physician: _____ Referring _____

Primary Insurance, name / address: _____

ID and Group# _____ Relation to patient _____

Secondary Insurance: _____

ID and Group# _____ Relation to patient _____

Please list three (3) people that we could contact in the event of an emergency:

1. _____ Ph# _____ Relationship: _____

2. _____ Ph# _____ Relationship: _____

3. _____ Ph# _____ Relationship: _____

Pharmacy: _____

I understand that I am responsible for checking with my insurance regarding any pre-certification and referral requirements.

Authorization for Release of Information
And Payment of Benefits

Comprehensive Pain Care, P.C.

770-421-8080 • Fax: 770-421-9566

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to the above state office of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under self-insurance program, or any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to the above stated office by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Print patient name and date of birth: _____

_____ _____

Signature of person providing the authorization — Date

_____ _____

Relationship to patient if not patient — Reason patient unable to sign