Pain Management Specialists of North Florida, PA
Raul A. Monzon, M.D.
Patient Face Sheet

Print Patient's Name Exactly As It Appears On The Insurance Card

_____ ☐ **Male** ☐ **Female**

LAST **FIRST** **MIDDLE**

Age _____ Birth Date _____ Social Security #_____ Marital Status **(circle one)** S M D W

Home #(_____)_____Work #(_____)_____ Cell # (_____)_____

Home Address _____

Mailing Address _____
(If Different From Above Address)

Current Employer_____ Address_____

E-Mail _____ Spouse's Name_____ Cell# _____

Emergency Contact_____ Relationship_____

Home #(_____)_____Work #(_____)_____Cell # (_____)_____

Medical Doctor _____City_____Phone #_____

Who referred you to our practice? _____Phone # _____

Have you or any of your family members had services here before ? ☐ No If yes, give name and date of services_____

Do you require a Language Interpreter? ☐ Yes ☐ NO **How did you find out about our facility?** ☐ Yellow Pages ☐ Magazine Ad ☐ Internet

☐ Oher_____

Is this visit related to an A**ccident**? ☐ **YES** ☐ **NO** ☐ **Auto** (Date of Accident)_____ ☐ **Work** (Date of Injury)_____

Attorneys Name:_____Phone #_____Contact_____

Primary Insurance Company_____

Policy Holder's Name_____
(As it appears on the card)

Birth Date _____SS#_____

Policy #_____Group#_____

Relationship to policy holder: ☐ Spouse ☐ Self ☐ Other

Secondary Insurance Company_____

Policy Holder's Name_____
(As it appears on the card)

Birth Date _____SS#_____

Policy #_____Group#_____

Relationship to policy holder: ☐ Spouse ☐ Self ☐ Other

WORKERS COMPENSATION

Name of Employer at the time of injury_____ Case #_____

Address_____ Phone #_____

Adjuster 's Name_____Nurse Case Manager's Name_____

Phone#_____Fax#_____ Phone#_____Fax#_____

Financial Responsibility Agreement and Signature Authorization

I authorize Raul A. Monzon, M.D. to administer medical care as necessary to use and disclose my protected health information for the purposes of Treatment, Payment and Health Care Operations. Pain Management Specialists of North Fl, PA will file my insurance as a courtesy on my behalf. I request that payment of authorized Medicare or any insurance benefits be made payable to Raul A. Monzon, M.D., Incorporated under Pain Management Specialists of North Fl, PA. I authorize any medical information or documentation about me in their possession be released to the Centers of Medicare and Medicaid Services (CMS) or Any Insurance Carrier, their Agents and Carriers as needed to determine these benefits or the benefits payable for related services, now or in the future. I agree to be financially responsible for all medical charges and services rendered to myself whether or not covered by my insurance. I accept responsibility for any balance not paid by my insurance company if not paid in 45 days. There will be a $30.00 fee on all returned checks. I agree to any cost of collections including attorneys fees, court cost and legal interest, which may be incurred in enforcing this obligation. I agree to contact Pain Management Specialists of North Fl, PA in the event my insurance and contact information changes. I have received and agree to the terms and conditions set by Pain Management Specialists of North Fl, PA's Financial Policy. I hereby authorize and direct that a copy of this authorization be accepted in place of the original and effective the date signed until revoked in writing.

Print Name:_____ **Signature**_____ **Date**_____

Witness Print Name:_____ **Signature**_____ **Date**_____