Peninsula Pain Clinic, PLLC

2601 Cherry Ave, Suite 200
Bremerton, WA 98310

(360) 415-9110 * (360) 479-0265 Fax

Completion of this information in its entirety is required at time of visit.

Last name: _____ **First name:** _____ **M.I.** _____ **Social Security #:** _____

Marital Status (check one): Single ❑ **Married** ❑ **Other** ❑ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph#: _____ **Work Ph#:** _____ **Other Ph#:** _____

Employer Name: _____ **E-mail:** _____

Employer Address: _____ **Employer phone#:** _____

IS THE PATIENT COVERED BY MEDICAL INSURANCE? ☐ **YES** ☐ **NO**
IS THIS AN AUTO OR L&I CLAIM? ☐ **YES** ☐ **NO** **If YES, provide DOI:** _____

Insurance information	Primary Insurance	Secondary Insurance
Insurance Name:		
Subscriber's ID#: **Claim #:**		
Group#:		
Subscriber's Name:		
Effective date:		
Co-payment required:		
Subscriber's Birth date: **Subscriber's SSN:**		
Patient relation to subscriber:		
Subscriber's Employer:		
Subscriber's address: **(if different than pt)**		
Subscriber's work phone#:		

Your insurance policy is a contract between you and your insurance company. We do not know the specifics of your particular policy and what it does or does not cover. This is your responsibility to understand prior to receiving care in our office. It is your responsibility to update our office of any changes or new information.

Authorization for Release of Information and Benefit Assignment:

- I hereby authorize Peninsula Pain Clinic, PLLC to release necessary medical information to my insurance carrier or their representatives for the purpose of processing claims for Peninsula Pain Clinic, PLLC for payment for services rendered.
- I hereby assign Peninsula Pain Clinic, PLLC all payments due by my medical plan or other liable insurance carrier for any and all services furnished by Peninsula Pain Clinic, PLLC

_____

Signature **Date**