

Valley Pain Center

John A. Wells, M. D.
BOARD CERTIFIED ACADEMY OF PAIN MANAGEMENT

PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (____) ____ - ____ Alternative #: (____) ____ - ____ D.O.B. ____ / ____ / ____ Age: ____
Marital Status: Single Married Divorced Separated Widow S.S. #: _____
E-Mail Address: _____
Occupation: _____ Work Number(____) ____ - ____
Employer: _____ Address: _____
Spouse Last Name: _____ First Name: _____ MI: _____
Employer: _____ Address: _____
Family Physician: _____ Phone Number: (____) ____ - ____
Nearest relative not living with you: _____
Address: _____ Phone: (____) ____ - ____ Relationship: _____
In case of emergency notify: _____ Phone: (____) ____ - ____

INSURANCE INFORMATION

*Primary Insurance: _____ Phone: (____) ____ - ____
Address: _____ City: _____ State: _____ Zip code: _____
Policy #: _____ Group#: _____
Insured Name: _____ D.O.B. ____ / ____ / ____ S.S. #: _____
*Secondary Insurance: _____ Phone: (____) ____ - ____
Address: _____ City: _____ State: _____ Zip code: _____
Policy #: _____ Group#: _____
Insured Name: _____ D.O.B. ____ / ____ / ____ S.S. #: _____

I authorize the release of medical information necessary to process claim and request all benefits to be paid to Dr. John A. Wells.

I understand and agree that I am ultimately responsible for payment on all charges incurred by myself. Any amount not covered by my insurance I understand that I will be personally responsible for payment at the time of service. I certify this information is true and correct to the best of my knowledge.

Signature: _____
(If minor, parental signature required.)

Date: _____