

# PAIN CONSULTANTS OF MICHIGAN, PLC



## PATIENT IDENTIFICATION

NAME: \_\_\_\_\_  
(First) (Middle Initial) (Last)

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ GENDER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_

CELL/WORK PHONE NUMBER: \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY PHONE NUMBER: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOW(ER)

RACE:  AMERICAN INDIAN/ALASKA NATIVE  BLACK/AFRICAN AMERICAN

NATIVE HAWWAIIAN/OTHER PACIFIC ISLANDER  ASIAN  WHITE

ETHNICITY:  HISPANIC/LATINO  NOT HISPANIC/LATINO

PRIMARY LANGUAGE:  ENGLISH  FRENCH  GERMAN

JAPANESE  MANDARIN  RUSSIAN  SPANISH

### BILLING INSURANCE INFORMATION:

INSURANCE NAME \_\_\_\_\_

INSURANCE SUBSCRIBER NAME \_\_\_\_\_

MEMBER ID \_\_\_\_\_ GROUP ID \_\_\_\_\_

### SECONDARY INSURANCE

INSURANCE NAME \_\_\_\_\_

INSURANCE SUBSCRIBER NAME \_\_\_\_\_

MEMBER ID \_\_\_\_\_ GROUP ID \_\_\_\_\_