Pain & Wellness Centers of GA
New Patient Form

Date:______________ **Spoke with**:____________________________ **DOB**____________________

Patient Name:___________________________________ **Address:**____

Phone #_____________________ **Other#**_______________________ **Employer:**_____________________________

How did you find out about our office?_____________________________________
Has the patient ever been treated by a pain facility? Y___ N____
If so, where?____
Contact Information:____

INSURANCE INFORMATION

Insurance Company:________________________________**ID#**________________________**Group#**______________________

Name of Insured:_________________________**DOB**___/___/_____**Relation:**_______________________________

Mailing address:____

Customer Service#____

Secondary Insurance:

Insurance Company:________________________________**ID#**________________________**Group#**______________________

Name of Insured:_________________________**DOB**___/___/_____**Relation:**_______________________________

Mailing address:____

Customer Service#____

Previous Treatment:

Dr.________________________ **City**____________________**Phone:**__________________**Fax:**___________________

Dr.________________________ **City**____________________**Phone:**__________________**Fax:**___________________

Dr.________________________ **City**____________________**Phone:**__________________**Fax:**___________________

MRI________________________**City**____________________**Phone:**__________________**Fax:**__________________

Pharmacy________________________ **City**____________________**Phone**________________**Fax**________________