CALIFORNIA PAIN CENTER

Van H. Vu, M.D.

Patient Registration

Date: ___/___/___ Home Phone:( ) ______-______

Name: ______________________________ Cell Phone: ( ) ______-______
Last First Middle

Social Security #: ______-______-______

Address: ______________________________

City: ______________________ State: __________ Zip: __________

Date of Birth: ______/______/______ Marital Status (S, M, D, W)_____ Sex_____ Drivers Lic #__________

Employer: ______________________________ Occupation: ______________

Notify in case of emergency: ______________________________ Phone:( ) ______-______

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*Primary Insurance Company: ______________________________ Phone #:( ) ______-______
(Please make sure to give the receptionist your card to copy.)

*Secondary Insurance Company: ______________________________ Phone #:( ) ______-______
(Please make sure to give the receptionist your card to copy.)

*Workers' Compensation Patients or Personal Injury *(if applicable)*:

Ins. Co. ______________________________ Phone #:( ) ______-______

Adjuster Name: ______________________________

Attorney: ______________________________ Phone #:( ) ______-______

Date of Injury________ Claim #: ______________________

Primary Care Physician ______________________ Phone number:( ) ______-______

Referring Physician ______________________ Phone number:( ) ______-______

Insurance Assignment and Consent to Release Information

**I hereby authorize the release of information to insurance carriers and/or Medicare concerning my diagnosis and/or treatment when concerning the payment of benefits. I hereby assign to Dr. Van H. Vu all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.

Patient/Guardian Signature ______________________ Date: ______________

**I acknowledge that I have received the *Notice of Privacy Practices.*

Patient/Guardian Initials ______________________ Date: ______________