David L. Spivey, MD
Medical Director
Anesthesiology & Pain Medicine

Mark H. Scheutzow, MD, PHD
Addictionology and Pain Medicine

Jeffery Adams, MD
Anesthesiology & Pain Medicine

PAIN MANAGEMENT & SPINE CARE, P.A.
Relieve Pain. Restore Function. . . Resume Life

www.PreferredPainManagement.com

Chad Caldwell, PA-C

PATIENT INFORMATION

Welcome to Preferred Pain Management & Spine Care. We would like your experience with us to be as positive as possible and appreciate the opportunity to introduce our operations to you.

Our office hours are Monday through Thursday from 8:00 AM to 5:00 PM, and on Friday from 8:00 AM to 12:00 PM. For your safety, we recommend care at the nearest Emergency Room after clinic hours, or if you are experiencing a medical emergency.

ALL NEW PATIENTS-YOU MUST BRING THE FOLLOWING ITEMS IN ORDER TO BE SEEN:

- **INSURANCE CARD(S)**
- **PICTURE ID**
- **ALL FORMS IN THE NEW PATIENT PACKET COMPLETED IN BLACK INK**
- **PRESCRIBED PAIN MEDICATIONS IN THEIR ORIGINAL CONTAINERS**
- **PRESCRIPTION DRUG COVERAGE (if applicable)**

*****DUE TO THE NATURE OF OUR PRACTICE WE REGRET TO INFORM YOU THAT WE CANNOT ACCOMMODATE CHILDREN UNDER THE AGE OF SIXTEEN (16) IN THE EXAM ROOMS, WAITING ROOM OR THE PARKING LOT*****

Please arrive 30 minutes before your first scheduled appointment. For disclosure of your protected health information, and/or for your health care power of attorney to be present in exam rooms, documentation of power of attorney must be presented at time of check-in. Also let us know if we may leave messages on your voicemail.

To avoid cancellation fees, please notify our office at least 24 hours prior to the date of your appointment. Multiple missed appointments may result in dismissal from our practice.

MEDICATION PROCESS

For your safety, our practice may or may not prescribe narcotics until we evaluate your health records and complete a urine drug screen. Additional studies may be ordered by your provider. Please note there will be **NO** early refills of narcotic medications unless directed by your physician. **NO MEDICATIONS WILL BE PRESCRIBED AFTER CLINIC HOURS.**

INSURANCE AND PAYMENT OPTIONS

As a courtesy we will file your insurance claim for those plans which we do participate. However, payment for any balance due is ultimately the patient's responsibility. Co-payments, coinsurance, deductibles, and past due balances are to be made at the time of service. We accept cash, Visa, MasterCard, Care Credit, and Discover. Patients without insurance coverage are expected to pay in full at the time of service. You may contact the office for fees at (336) 760-0706. **Please note our practice does not determine disability.**

WE LOOK FORWARD TO SERVING YOU.

Sign: ______________________________ **Date:** ______________

Print Name: ______________________________

2912 Maplewood Avenue • Winston Salem, NC 27103 • Telephone: 336.760.0706 Fax: 336.760.1927
1511 Westover Terrace, Suite 107 • Greensboro, NC 27408 • Telephone: 336.398.5155 Fax: 336.398.5156

Preferred
PAIN MANAGEMENT & SPINE CARE, P.A.

Patient Demographic Form

Date: ______________

PLEASE PRINT

PATIENT INFORMATION			
LAST NAME: Jr., Sr., II, III	FIRST NAME	MIDDLE INITIAL	NICKNAME/MAIDEN NAME
DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER ❑MALE ❑FEMALE	
MARITAL STATUS ❑ SINGLE ❑MARRIED ❑DIVORCED ❑SEPARATED ❑WIDOWED ❑LIFE PARTNER			
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYMENT STATUS ❑FULL TIME ❑PART TIME ❑HOMEMAKER ❑NOT EMPLOYED ❑RETIRED ❑SELF EMPLOYED ❑STUDENT FULL TIME ❑STUDENT PART TIME ❑ACTIVE DUTY MILITARY ❑CHILD ❑DISABLED ❑OTHER			
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
MAY WE LEAVE VOICE MESSAGES ON YOUR PHONE? ❑YES ❑NO	EMAIL ADDRESS		

PHYSICIAN REFERRAL INFORMATION	
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

PRIMARY INSURANCE INFORMATION			
POLICY HOLDER NAME (LAST, FIRST, MI)		NAME OF INSURANCE COMPANY	
POLICY HOLDER DATE OF BIRTH	RELATIONSHIP TO PATIENT	POLICY HOLDER SOCIAL SECURITY NUMBER	
POLICY HOLDER HOME ADDRESS	CITY	STATE	ZIP CODE
POLICY HOLDER HOME PHONE	POLICY HOLDER WORK PHONE	POLICY HOLDER CELL PHONE	
POLICY HOLDER EMPLOYER	POLICY HOLDER EMPLOYER ADDRESS	POLICY HOLDER EMPLOYER PHONE	
POLICY NUMBER		GROUP NUMBER	

SECONDARY INSURANCE INFORMATION			
POLICY HOLDER NAME (LAST, FIRST, MI)		NAME OF INSURANCE COMPANY	
POLICY HOLDER DATE OF BIRTH	RELATIONSHIP TO PATIENT	POLICY HOLDER SOCIAL SECURITY NUMBER	
POLICY HOLDER HOME ADDRESS	CITY	STATE	ZIP CODE
POLICY HOLDER HOME PHONE	POLICY HOLDER WORK PHONE	POLICY HOLDER CELL PHONE	
POLICY HOLDER EMPLOYER	POLICY HOLDER EMPLOYER ADDRESS	POLICY HOLDER EMPLOYER PHONE	
POLICY NUMBER		GROUP NUMBER	

EMERGENCY CONTACT INFORMATION			
LAST NAME	FIRST NAME	PHONE	RELATION TO PATIENT
HOME ADDRESS	CITY	STATE	ZIP CODE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any otherwise payable to me for their services as described below but not to exceed the reasonable and customer charge for those services. I request that payment of authorized Medicare benefits me made either to me or on my behalf to Preferred Pain Management and Spine Care, P.A. for any services furnished to me by that Association.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Health Care Financing Administration and its agents and to specific insurance carriers, third party payers or others involved in processing and collection of this claim as needed to determine these benefits for related service.
FINANCIAL RESPONSIBILITY: The undersigned guarantees payment to Preferred Pain Management and Spine Care, P.A. for services rendered in the event insurance does not cover all fees.

SIGNATURE: ______________________________ DATE: ______________________

REVISED 5/26/15