

SPACE COAST PAIN INSTITUTE

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NEW PATIENT INFORMATION

Patient's name _____ Today's date _____

Date of birth _____ Sex _____ SSN _____

Home Address _____

Home phone _____ Work phone _____

E-Mail: _____

Employer _____ Occupation _____

Marital status _____ Name of spouse _____

Primary Insurance Company _____ Policy Number _____

Name of Insured _____

Insured date of birth _____ Insured SSN _____

Secondary Insurance Company _____ Policy Number _____

Name of insured _____

SSN of insured _____ Insured date of birth _____

Did your injury occur on the job? Yes _____ No _____

Automobile accident? Yes _____ No _____

Other accident? Yes _____ No _____

Financial Agreement

1. I accept responsibility for the balance that my insurance company does not cover.
2. I understand that I am fully responsible for the payment of services rendered and agree to pay any co pays, co-insurance, and/or deductibles for office visits and/or procedures prior to procedure date.
3. I hereby authorize my insurance company to pay all medical or government benefits directly to Space Coast Pain Institute according to the terms of my policy.
4. I authorize the release of any and all my medical information, including super sensitive information, necessary to process this claim. I authorize and appoint Space Coast Pain Institute to collect any claims or insurance proceeds on my behalf.

I acknowledge that the demographic and insurance information listed above is correct.

Signature: _____ **Date:** _____

*** Please present this form and all insurance ID cards to the receptionist at this time.***