St. George Spine and Pain Institute

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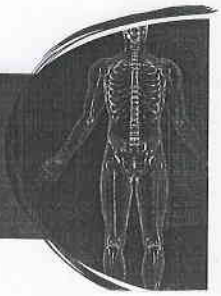

PATIENT INFORMATION

Date_____ Date of Birth_____

Name_____ Sex (Circle one) M F SS # _____

Home Phone_____ WK Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Employer_____ Phone #_____

Employer Address_____ City_____ State_____ Zip_____

Nearest Relative not Living with you_____ Phone# _____

INSURANCE INFORMATION

Primary Insurance_____ Effective Date_____

Subscriber name_____ Patient name_____

Group or plan number_____ Insurance phone _____

Secondary Insurance_____ Effective Date_____

Subscriber name_____ Group or Plan number_____

Workman's comp Insurance (If applicable) _____ Phone # _____

Date of Injury____/____/____ Claim # _____ Adjuster name_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named agency to release any treatment information requested by attorney's, physicians, insurance companies, health care providers or any other entity and in the case of referral to the Cypress Pain Management Program to Dr. Gareth Houghton PhD, Claudine Velosa, R.N. and Cypress outpatient therapy who may be concerned with the payment of charges incurred for the treatment services rendered by physicians and staff. I hereby authorize payment directly to the physician of the insurance benefits otherwise payable to me. I am responsible for payment of all services rendered by the physician, not covered by insurance.

Date_____ Patient Signature_____
(Parent or Guardian if Minor)