INTERVENTIONAL
PAIN ASSOCIATES (IPA)
4613 Bee Caves Road #105, Austin, TX 78746
(P):512-795-7575 (F): 512-795-7592
www.interventionalpainassociates.com

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Age: _____ Sex: M F Marital Status: S M D W Social Security No: _____

Driver's License No: _____ State: _____ Expiration: _____

Patient's Employer: _____ Position: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse/ Patient if patient is under 18 years old: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone No: _____ Relationship: _____

Referred by: _____ Chief complaint: _____

Allergies to Medications: _____

INSURANCE INFORMATION:

Name of Primary Insurance Company: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Insurance ID No: _____ Insurance Group No: _____

Name of Secondary Insurance Company: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Insurance ID No: _____ Insurance Group No: _____

IMPORTANT INFORMATION

PRESENT YOUR INSURANCE CARD: Payment is expected at the time service is rendered. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid by your insurance company. Dr. Saleemi does not accept Medicaid. Any balance owed by Medicaid is the responsibility of the patient. I hereby assign all medical benefits, including Medicare, private Insurance, and other Plans to Sarosh Saleemi, M. D. I understand that I am responsible for all charges whether or not paid by said insurance. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of patient's record.

Patient or Authorized Signature: _____ Date: _____