Pain Management Physicians of South Florida, PL

Andrew J. Goldberg, M.D. Seth C. Wachsman, M.D.

8880 Royal Palm Blvd. Suite 103. Coral Springs, Florida 33065
OFFICE NUMBER: (954) 975-8233 FAX: (954)974-2335

PERSONAL INFORMATION

TODAY'S DATE _____/_____/_____

First Name: _____Last Name: _____SS#: _____

Permanent Address: _____City: _____ St: _____ Zip: _____

Phone: _____Sex: _____ Date of Birth: _____Age: _____

Marital Status _____ Emergency Contact: _____ Phone: _____

Employer: _____Phone: _____

Your Drug Store: _____Phone: _____ City: _____

INSURANCE INFORMATION

All patients, we ask that you provide us with your photo id and insurance cards, both primary and secondary. We will photocopy them for our files. Per visit CO-PAYS will be collected at the time of the visit. Please be prepared to pay your co-pay.

Primary Insurance Company: _____Phone: _____

Is this: ☐ Medicare ☐ Medicare HMO ☐ PPO ☐ HMO ☐ Other
Contract #: _____ Group #: _____ Subscriber #: _____

Name of Policy Holder: _____ SS#: _____ DOB: _____

Relationship to Patient: _____ Co-pay Amount: _____

Secondary Insurance: _____ Subscriber: _____ Contract # _____

Do you need a referral from your regular doctor to see a specialist: ☐yes ☐no

Referring Doctors' Name Phone Number Address:

_____ _____ _____

Primary Care Physicians' Name Phone Number Address:

_____ _____ _____

HIPPA QUESTIONS

As my doctor, you or your staff may:
___ Call my home/cell phone and if necessary leave a message on my voice mail/answering machine or with family for me to call you back to schedule an appointment or to return your call.
___Call my workplace and if necessary leave a message for me to call you back to schedule an appointment or to return your call.

_____ _____ _____
Patient's Signature Patient's Printed Name Date