Robert Frey, M.D.
Pacific Pain Management, Inc.
1280 S. Victoria Ave. Ste. 204
Ventura CA 93003
Ph 805.644.4930 ~ Fx 805.654.1284

PATIENT INFORMATION

Patient's Name:_____ Date of Birth:_____
FIRST MIDDLE LAST

SSN:_____ DL#:_____ Male:____ Female:____ Age:____

Address:_____ City:_____ State:____ Zip:_____

Home #:_____ Cell #:_____ Work #:_____

Employer:_____ Occupation:_____

Marital Status: S____ M____ D____ Other____ Email:_____

Spouse's Name:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

Who Were You Referred By?:_____ Phone #:_____

Primary Care Doctor:_____ Phone #:_____

Race:_____ Ethnicity:_____ Primary Language:_____

INSURANCE INFORMATION

Insurance Company:_____ Policy ID #:_____

Secondary Insurance:_____ Policy ID #:_____

CONSENT TO BILL FOR SERVICES RENDERED

_____ _____
PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

I hereby assign all medical benefits to which I am entitled to Robert Frey, M.D., in the event they file insurance claims on my behalf. I understand that I am financially responsible for all charges, whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the amount owed as well as all reasonable cost associated with the collection of this debt, including but not limited to collection service fee, attorney fees, and all additional fees/court costs associated with the recovery of the debt. I hereby authorize said assignee to release all information necessary to secure payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I hereby consent to such treatment by the authorized personnel of Robert Frey, M.D., as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of medical negligence.