

Miguel Pupiales, MD PC
4163 Montgomery Blvd NE, Albuquerque, NM 87109
Telephone (505) 344-7246 (PAIN) Fax (505) 344-2666

Date: _____

PATIENT INFORMATION

Name _____ DOB ____/____/____ SS# ____/____/____
(last) (first) (middle)

Home Address: _____

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

Please Circle: Male/Female Marital Status: Single/Married /Divorced/Windowed

Person to contact in case of emergency: _____ Phone #: _____ - _____ - _____
(Name) (Relationship)

Friend or relative not living with you: _____ Phone #: _____ - _____ - _____
(Name) (Relationship)

REFERRED BY: _____ **PRIMARY CARE PHYSICIAN:** _____
PHONE #: _____ PHONE #: _____

CURRENT EMPLOYMENT INFORMATION

Employed: F/T P/T Retired Unemployed F/T Student P/T Student
Employer: _____ Work # _____ - _____ - _____ Ext _____

Address: _____ Supervisor: _____
_____ Position: _____

Is this injury: Work Related: _____ Auto Accident: _____ Date of Injury: ____/____/____

WORKERS' COMPENSATION INSURANCE INFORMATION

Work Comp Insurance Company: _____
(Name)

(Address, City, State, Zip Code)

Adjuster's Name: _____ Phone# _____ - _____ - _____
Medical Case Manager: _____ Phone# _____ - _____ - _____

Date of Injury: ____/____/____ Employer at time in injury: _____
Claim# _____

RESPONSIBLE PARTY INFORMATION (if patient is not responsible)

Name _____ DOB ____/____/____ SS# ____/____/____
(Last) (First) (Middle)

Home Address: _____

Home# ____-____-____ Male/Female Marital Status: Single Married Divorced Widowed

Relationship to Patient: _____

Employer: _____ Work# ____-____-____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____
(Name, Address, City, State, Zip Code)

Group # _____ ID # _____ Phone# ____-____-____

Insured's Name: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company: _____
(Name, Address, City, State, Zip Code)

Group # _____ ID # _____ Phone# ____-____-____

Insured's Name: _____ Relationship to Patient: _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize payment of medical benefits directly to Miguel Pupiales, MD PC for treatment of this injury/illness.

AUTHORIZATION TO TREAT AND RELEASE INFORMATION

I hereby authorize Miguel Pupiales, MD PC to examine and treat as necessary. The physician may release information acquired in the course of this examination or treatment to my employer, insurance carrier, or any other physician, if requested by me or my employer. The undersigned also authorizes Miguel Pupiales, MD PC to release to the prospective employer, insurance carrier, or any other physician whether by phone, fax, or mail. Any and all information held by Miguel Pupiales, MD PC may have been obtained from any prior examination procedure or treatment rendered to the undersigned by Miguel Pupiales, MD PC.

Patient Signature: _____ Date: _____

PATIENT IS RESPONSIBLE FOR PAYMENT OF DENIED CLAIMS