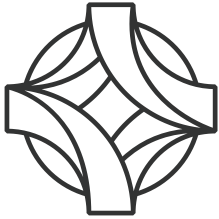

Lipson Pain Institute
RELIEVING PAIN • CHANGING LIVES

Ana D. Lipson, M.D.
210 First Street North
Winter Haven, FL 33881
Phone: 863-293-4800
Fax: 863-293-4410

Date ________________________

PATIENT INFORMATION

Name: ____ Home Phone: ____________________
LAST FIRST INITIAL XXX-XXX-XXXX

Address: ____ Cell Phone: ____________________
XXX-XXX-XXXX

City: ______________________ State: ________ Zip Code: ______________ Social Security No.: ____________________
XXX-XX-XXXX

Sex: ❑ M ❑ F Date of Birth ____________________ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
MM-DD-YEAR

Email: ______________________________ Preferred Contact Method: ❑ Home ❑ Cell ❑ Text ❑ Email

Employer: ______________________ Occupation: ______________________ Work Phone: ____________________
XXX-XXX-XXXX

SPOUSE / EMERGENCY CONTACT

Spouse/Partner/Name: ____ Cell Phone: ____________________
LAST FIRST INITIAL XXX-XXX-XXXX

Date of Birth: ____________________ Relationship to Patient: ______________________
MM-DD-YEAR

Employer: ______________________ Occupation: ______________________ Work Phone: ____________________
XXX-XXX-XXXX

In Case of Emergency, Notify: ____
NAME RELATIONSHIP PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's Name: ____ Date of Birth: ____________________
LAST FIRST INITIAL MM-DD-YEAR

Insurance Company: ______________________________ Subscribers Social Security No.: ____________________
XXX-XX-XXXX

Policy #: ____________________ Group #: ______________ Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY INSURANCE

Subscriber's Name: ____ Date of Birth: ____________________
LAST FIRST INITIAL MM-DD-YEAR

Insurance Company: ______________________________ Subscribers Social Security No.: ____________________
XXX-XX-XXXX

Policy #: ____________________ Group #: ______________ Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

ASSIGNMENT & RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LIPSON PAIN INSTITUTE or insurance company to release any information required to process my claims.

____ ______________________________
PATIENT / GUARDIAN SIGNATURE DATE