PETER N. PIPERIS, MD, DABPM
GRIFFITH F. EVANS, MD
REED JARECKE, PA

MOMENTA PAIN CARE, LLC
1805 NORTH 145 STREET
OMAHA, NE | 68154
p 402.991.6559
f 402.991.3552

Regenexx™ The Trusted Alternative to Orthopedic Surgery

momenta PAIN CARE

Move. Forward.

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER PATIENT DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ CELL: _____ WORK: _____

EMAIL ADDRESS: _____ PREFERRED CONTACT METHOD: ☐ HOME ☐ WORK ☐ CELL ☐ EMAIL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE: ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN OR PACIFIC ISLANDER ☐ BLACK ☐ WHITE ☐ DECLINE TO SPECIFY

ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ DECLINE TO SPECIFY PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN REFERRAL_____(NAME) ☐ FRIEND/FAMILY_____(NAME)
☐ GOOGLE ☐ SOCIAL MEDIA ☐ WEBSITE ☐ MAGAZINE ☐ OTHER_____.

EMPLOYMENT

☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ DISABLED

EMPLOYER: _____ OCCUPATION: _____

PHARMACY

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO THE PATIENT: _____ DOB: _____

ARE WE AUTHORIZED TO DISCUSS YOUR MEDICAL CARE WITH THIS PERSON: ☐ YES ☐ NO

IS THIS PERSON AUTHORIZED TO MAKE MEDICAL DECISIONS ON YOUR BEHALF: ☐ YES ☐ NO

RELEASE OF HEALTH INFORMATION

I AUTHORIZE MOMENTA PAIN CARE TO RELEASE MY HEALTH & BILLING INFORMATION TO:

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

APPOINTMENT REMINDERS: IN THE EVENT I AM UNREACHABLE, I AUTHORIZE MOMENTA PAIN CARE, TO LEAVE A MESSAGE REGARDING MY APPOINTMENT TIME, CHANGES OR SCHEDULING INFORMATION ON MY ANSWERING MACHINE, VOICEMAIL OR WITH THE PERSON ANSWERING THE PHONE.

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS OR CHANGES: ☐PHONE ☐EMAIL ☐TEXT ☐OTHER_____

POLICY NOTICE RECEIPT OF ACKNOWLEDGEMENT (INITIAL)

_____ I ACKNOWLEDGE THAT I WAS OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.
INITIAL

***PLEASE BRING YOUR INSURANCE CARD(S) AND ID ON THE DAY OF YOUR APPOINTMENT AND ARRIVE 15 MINUTES EARLY**

INSURANCE

CARRIER: _____ ADDRESS: _____

POLICY #:_____ ACCOUNT #_____

BENEFIT CODE: _____ EFFECTIVE DATE: _____

PRECERTIFICATION REQUIRED? ☐ YES ☐ NO CONTACT: _____

POLICY HOLDER (IF DIFFERENT THAN PATIENT): _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

YES, EMPLOYER NAME: _____

SECONDARY INSURANCE

CARRIER: _____ ADDRESS: _____

POLICY # _____ ACCOUNT #_____

BENEFIT CODE: _____ EFFECTIVE DATE: _____

PRECERTIFICATION REQUIRED? ☐ YES ☐ NO

CONTACT: _____

POLICY HOLDER (IF DIFFERENT THAN PATIENT) _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

IF YES, EMPLOYER NAME: _____

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POLICY HOLDER (IF DIFFERENT THAN PATIENT): _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

YES, EMPLOYER NAME: _____

SECONDARY INSURANCE

CARRIER: _____ ADDRESS: _____

POLICY # _____ ACCOUNT #_____

BENEFIT CODE: _____ EFFECTIVE DATE: _____

PRECERTIFICATION REQUIRED? ☐ YES ☐ NO

CONTACT: _____

POLICY HOLDER (IF DIFFERENT THAN PATIENT) _____ DATE OF BIRTH: _____

INSURED THROUGH EMPLOYMENT? ☐ YES ☐ NO

IF YES, EMPLOYER NAME: _____