Estela Diesfeld, M.D.
Pain Specialty Center
1752 S. Victoria Ave. Ste. B
Ventura, Ca 93003
(805) 644-4930 (805) 644-4960 Fax

PATIENT' S INFORMATION

Patient's Name_____Date of Birth _____
First Middle Last
Address _____Age_____

City _____State _____ZIP _____

Phone # _____ Social Security # _____ License #_____

Employer_____Address_____City_____

Employer's Phone # _____Date Of Employment_____ Occupation_____

Marital Status Single____ Married____ Divorced____ Widowed____ Other____

Race: Caucasian_____ Asian _____ Eastern Indian _____ Arab _____
Hispanic _____ Native American _____ African American _____

Spouse's Name_____ Date of Birth_____SSN #_____

Spouse's
Employer_____Address_____City_____

Phone #_____Date of Employment_____Occupation_____

Who where you referred to us by?_____Phone #_____

In case of emergency please contact_____Phone #_____

Relationship: _____

INSURANCE INFORMATION

Insurance Name _____Policy # _____ Effective Date_____

Address_____City _____State_____ZIP_____

Name of policy holder _____Date of Birth_____SSN #_____

Is this a work injury? _____Date of injury _____ Part of body injured_____

Adjustor's Name _____ Claim #_____

Adjustor's Phone #_____ Fax # _____

Our office will bill your insurance. You are responsible for the deductible share of cost, co-payment at time of visit, and any costs not a benefit of your plan. If you do not have insurance we would appreciate payment at the time of your visit. Our staff is available if you have any questions. I authorize payment of medical benefits to be made directly to the physician provider for services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this from to bill my insurance companies.

_____ _____
Patient Signature Date