Arnulfo Tarín Carrasco, M.D.
Diplomate American Academy of Pain Management
Medical Director – Anesthesiologist - Algologist

Patient Registration/Demographic/Insurance Form

Personal Demographic Information *Today's Date:_____/_____/____*

Name:_____Acct #:_____DOB:_____/_____/_____Age:_____

Address:_____Hm Phone:( )_____SS#_____/_____/_____

City:_____State:_____Zip:_____E-Mail:_____

Cell: ( )_____ Work: ( )_____Other: ( )_____

Employer (at time of injury if workers' comp.):_____Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

License State/#:_____Marital Status: S D W M Spouse Name:_____

How were you referred?: Self Newsletter Physician Phone book Friend Website Other:_____

Emergency Contact (other than spouse)

Name:_____Relationship:_____ Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

Referring Physician:

Physician's Name:_____ MD / DO / DPM / DC Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

UPIN #:_____NPI #:_____Lic #:_____Fax # ( )_____

Family Physician:

Physician's Name:_____ MD / DO / DPM / DC Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

UPIN #:_____NPI #:_____Lic #:_____Fax # ( )_____

Workers' Compensation Information:

Insurance Carrier:_____Adjustor:_____Ext #:_____

Address:_____ City:_____State:_____Zip:_____

Claim #:_____DOI:_____/_____/_____ Phone ( )_____

Allowed Conditions:_____ Fax # ( )_____

Preauth Co:_____ Phone ( )_____ Fax # ( )_____