

Highland Hospital Pain Management Center
990 South Ave Suite 210
Rochester, NY 14620
Phone: 244-7748
Fax: 244-7610

Patient Name _____ Male/Female _____

Diagnosis

D.O.B _____ SS# _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____

Referring MD _____ Address _____

Phone _____
Primary MD _____ Address _____

Phone _____

Insurance Information

Compensation Insurance

Carrier _____ DOI _____
WCB _____ CC# _____ Employer _____
Address _____ State _____ Zip _____
Phone _____ Fax _____ Contact _____

MVA Carrier _____ Case# _____
Address _____ State _____ Zip _____
Phone _____ Fax _____ Contact _____

Blue Choice _____ MVP _____
Blue Choice Option _____ Aetna _____
BCO referral# _____ United Health Care _____
Medicare _____ Medicaid _____
Other _____

Please fax over last 2-3 office notes and any X-Ray's, CT's or MRI's. Thank you!!