



Dr. Graf Hilgenhurst
1177 Rock Springs Road, Suite 120
Smyrna, TN 37167
615-223-6200, fax 615-223-6100

Thank you for referring to Precision Pain Care! Please fax this form along with copy of patient's insurance card, last office notes as well as any applicable diagnostic imaging reports. We will call patient to schedule appointment.

Date: _____

Referring Physician: _____

Phone #: _____ Contact person: _____

Has patient been to a pain clinic previously? Yes / No

(These records are required before patient will be considered for admission to PPC)

Type of service requested:

Transfer of care for this problem: _____

Consultation (opinion): _____

Procedure only (follow up with your office): _____

Pt Diagnosis: _____

Pt Name: _____

DOB: _____

Address: _____ SS#: _____

_____ Zip: _____

Phone #:

Home: _____ Cell: _____

Work: _____

Insurance Information: if workman's compensation please send claim #, DOI, billing address and adjuster name and phone number

Insurance Co: _____ Phone _____

Insured Name: _____

Employer: _____

Insured SS#: _____ Insured DOB: _____

Insurance ID#: _____ Group #: _____

Referral/Precertification required: Yes/No

Certified by: _____

Precert #: _____

Precision Pain Care Use Only

Benefits Verified by: _____ Effective Date: _____

Office CoPay: _____ Out pt surg Copay: _____

Co Ins: _____ Deductible: _____

Pt appt scheduled for: _____

Procedure pt: Allergies _____

NPO 6 hours before procedure _____

Do you take Blood thinners? Yes / No

If Yes, Which one _____