

ARUL DORAISWAMY, MD, APC
The Pain Clinic

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Patient Information

Name (Last, First, M.I.) _____

Address _____ Date of Birth _____ Age _____ M/F

City and State _____ Zip _____

Phone# _____ Cell# _____ Marital Status: Single Married Divorced Widowed

Email Address _____ Social Security# _____

Emergency Contact (Not Living With You) _____ Phone # _____

Referring Physician _____ Phone # _____

Employer _____ Occupation _____

Address _____ Phone # _____

Insurance Information

Insurance Company _____ Customer Service# _____

Billing Address _____ Prior Authorization# _____

City and State _____ Zip _____

Subscriber Name _____ Subscriber Date of Birth _____

Insurance ID# _____ Subscriber Social Security# _____

Group/Account# _____ Effective Date _____

Subscriber Employer _____ SubscriberPhone# _____