Pain Diagnostics
and Treatment Center, P.A.

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Timothy N. Zoys, M.D.

FROM:

Requesting Physician: _____ Specialty: _____

Address: _____ City: _____ State/Zip: _____

Office Phone #: _____ Office Contact: _____ UPIN #: _____

SERVICE REQUESTED: (Check one)

☐ Consult with Procedure (if necessary) ☐ Evaluate and Treat

☐ Consult only ☐ Other: _____

☐ Referral for Procedure (specify below)

PROCEDURE ONLY: (Check)

☐ Facet Injection(s) ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Caudal

☐ Epidural Steroid Injection Level(s): _____

☐ Selective Nerve Root Injection ☐ Right ☐ Left

☐ Sacroiliac Joint Injection

☐ Other: _____

Special instructions: _____

DIAGNOSIS: 1) _____ 2) _____

3) _____ 4) _____

CONFIRMATORY TESTING: ☐ CT ☐ MYELOGRAM ☐ MRI ☐ EMG/NCV ☐ X-RAY

_____

Patient Name: _____ SS #: _____

Address: _____ City: _____ State/Zip: _____

Home Ph #: _____ Work Ph #: _____ DOB: _____

BILLING INFORMATION (copy of insurance face sheet or insurance card is acceptable)

Insurance Carrier:		Adjuster Name:	
Insurance Co. Phone #:		Place of Employment:	
Policy Holder's Name:		Employer's Phone #:	
Policy Number:	Group Number:	W/C Claim #:	Date of Injury:

PLEASE FAX COPY OF H&P / SUMMARY AND RECENT PROGRESS NOTES

www.DallasPainCenter.com www.GarlandPainCenter.com