



**PIEDMONT**  
*Interventional*  
**PAIN CARE, PA**

Robert B. Wilson, II, MD  
Pain Medicine Specialist  
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Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Male  Female

**Primary Insurance:** \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Claim Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Claim Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Patient is Referred for:**

- |   |   |
|---|---|
| <input type="checkbox"/> Myofascial pain (muscle pain)                | <input type="checkbox"/> Lumbar facet arthropathy (low back joint pain) |
| <input type="checkbox"/> Cervical facet arthropathy (neck joint pain) | <input type="checkbox"/> Lumbar degenerative disc disease               |
| <input type="checkbox"/> Cervical degenerative disc disease           | <input type="checkbox"/> Back and leg pain                              |
| <input type="checkbox"/> Neck, shoulder and arm pain                  | <input type="checkbox"/> Sciatica (radicular pain)                      |
| <input type="checkbox"/> Occipital headaches                          | <input type="checkbox"/> Shingles (herpes zoster) pain                  |
| <input type="checkbox"/> Thoracic facet arthropathy (back joint pain) | <input type="checkbox"/> Complex regional pain syndrome (CRPS)          |
| <input type="checkbox"/> Thoracic degenerative disc disease           | <input type="checkbox"/> Reflex sympathetic dystrophy (RDS)             |
| <input type="checkbox"/> Indicate Procedure (if applicable) _____     | <input type="checkbox"/> Cancer Pain                                    |
| _____   | <input type="checkbox"/> Other (explain) _____                          |
| _____   | _____   |
| _____   | _____   |

- Please fax all medical records, radiology reports and insurance card
- Please send insurance referral if required
- Omitted information will delay our ability to respond to your request promptly
- We will fax the appointment back to you to advise your patient

**Office Hours:** M-Th: 7:30 am - 5:00 pm; F: 7:30 am - 2:00 pm