CENTER for PAIN RELIEF

PATIENT REGISTRATION FORM

Please Print

Date _____ Home Phone _____ Cell Phone _____

PATIENT INFORMATION

Name _____ SS / HIC / Patient ID # _____
Last Name *First Name* *Middle Initial*

Address _____ Email _____

City _____ State _____ Zip Code _____

Sex: ☐ Male ☐ Female Age _____ Birthdate _____ ☐ Minor ☐ Single ☐ Married ☐ ☐ Partnered for ___ years
☐ Seperated ☐ Divorced ☐ Widowed

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible
for Account _____ Relation to Patient _____
Last Name *First Name* *Middle Initial*

Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Employed By _____ Occupation _____

Bus. Address _____ Bus Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Person Responsible
for Account _____ Relation to Patient _____
Last Name *First Name* *Middle Initial*

Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Employed By _____ Occupation _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ Name of Insurance Company(ies) an authorize payment directy to Dr. _____ of all insurance benefitsm if anym otherwise payable to me for services rendered. I understand that I am financially responsible for the charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use my signature on all insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patientm Parent, Guardian or Person Responsible *Date*

_____ _____
Please print name of Patient, Parent, Guardian or Person Responsible *Relationship to Patient*