PALMETTO PAIN MANAGEMENT

PAIN MANAGEMENT & SPINAL DIAGNOSTICS

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Singe / Mar / Div / Sep

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	City:	State:	Zip Code:

Driver's Lic#	Social Security no.:	Home Phone:

Occupation:	Employer:	Employer Phone no.:

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for bill:	Birth Date: / /	Address (If different):	Home phone no.: ( )

Is this person covered by Insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ [Insurance]	Ins Name:	Phone#	

Address:	State:	Zip Code:	☐ Other

Subscriber's Name:	Subscriber's S.S. no.:	Birth date: / /	Group No#	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's Name:		Group No#	Policy No#

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize {Name of Practice or insurance company to release any information required processing my claims.

_____ _____

Patient/Guardian signature *Date*