Pain Management Institute
Patient Registration

Language____________________

Deaf _____ Yes _____ No

Ethnicity: Check one

- ☐ African American
- ☐ American Indian
- ☐ Chinese
- ☐ European American
- ☐ Hispanic
- ☐ Latino- Not Hispanic
- ☐ Not Latino

Race: Check One

- ☐ African American
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ Other Islanders
- ☐ White

Patient Information (Please print):

Name: ____________________

Address: ____________________ City: __________ St: ______ Zip: __________

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________ SS#: ____________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Employer: ____________________

Address: ____________________ City: __________ St: ______ Zip: __________

Work Phone: ____________________ May we call you at work? __________

Spouse's Name: ____________________

Spouse's Employer: ____________________

Spouse's Work Phone: ____________________

Emergency Contact Information (Please provide someone other than your spouse):

Name: ____________________ Phone Number: ____________________

Pharmacy: ____________________ Phone Number: ____________________

Insurance Information

Primary Insurance: ____________________

Insured's Name: ____________________

Relationship to Patient: ____________________

Insured's address: ____________________ City: __________ St: ______ Zip: _____

Date of Birth: ____________________ SS#: ____________________

11/2/10

(over)

Pain Management Instituted

Patient Registration

Patient Name: ______________________________

Insurance Information (Continues):

Secondary Insurance: ______________________________

Insured's Name: ______________________________

Relationship to patient: ______________________________

Insured's address: ______________ City: __________ St: ______ Zip: ____

Date of Birth: ______________ SS#: ______________

Please provide our office with copies of your insurance cards.

Do you have a living will or durable healthcare power of attorney? If do, please provide our office with a copy for your chart.

I hereby authorize pain management institute to disclose or receive any or all information relating to my evaluation at this office, including copies of my diagnostic test results, to or from my attending physician and/ or treatment information which he/ she believes is indicated.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR, OR GROUP INDICATED ON THE CLAIM. I am responsible for any referrals and/or authorizations required by my insurance company. I understand that I am financially responsible for any balances not covered by my insurance.

I understand that Pain Management Institute is NOT responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I am responsible for any co-payments, deductibles, and fees for non-covered services.

I understand that Pain Management Institute is NOT in the business of extending credit, and I agree to pay Pain Management Institute at the time its bill is presented. If prompt payment is not made Pain Management Institute may take action to collect charges.

Signature: ______________________ Date: ______________