Patient Registration Form

Personal Information

Date:

Last Name	First Name	MI	Title	Marital Status
Is this your legal name? If not, please list legal name.	Birthdate:	Age:	Sex:	Last five digits of Social Security Number

Street Address PO Box City, State Zip Code	Home Number	Cell Number	Email

Occupation	Employer Name & Address	Employer Work Number	Work Extension

Primary Care Physician:	Primary Care Address

Insurance Information

Is the patient covered by insurance? ☐ Yes ☐ No

Insurance Name	Subscriber Number	Group Number

Subscriber Name	Subscriber Birthday	Subscriber Sex	Relationship to Subscriber
Person Responsible for Bill	Address (if different)	Birthdate	Best Phone Number

Other Insurance if Applicable

Insurance Name	Subscriber Number	Group Number

Subscriber Name	Subscriber Birthday	Subscriber Sex	Relationship to Subscriber
Person Responsible for Bill	Address (if different)	Birthdate	Best Phone Number

Emergency Information

Name of Emergency Contact	Relationship to Patient	Cell Number	Home Number	Address

Assignment of Benefits

I affirm the above information is true. I assign my benefits to Pain Solutions and authorize my insurance to pay benefits directly to Pain Solutions. I understand that I am financially responsible for any balance. I also authorize Pain Solutions to release any information required to process my claims. On that basis, Pain Solutions may use my health care information and may disclose such information to the above listed insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits available for related services.

Name of Financially Responsible Party	Signature of Financially Responsible Party	Date